

Can I be helped? The prospects for change in me and my depression: a thematic analysis of pre-therapy expectations.

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Abstract

While clients' expectations are understood to contribute significantly to outcomes in therapy, attempts to understand this contribution have been confusing, and there is a paucity of research on the subject for adults with depression seeking therapy. This is significant given that people with depression are less likely to seek help and have higher rates of pre-therapy attrition compared to people with other presentations. Moreover expectations for therapy are likely to play a role in clients' early engagement in therapy, which is seen to be a critical phase for improvement. This research provides a qualitative account of the pre-therapy expectations of twelve adults who were on waiting lists to receive psychological therapy for depression. A thematic analysis was carried out on the data obtained from semi-structured interviews which explored participants' experiences of depression and help-seeking, and their expectations for therapy. The first overarching theme, *Therapy – A faint hope*, explored the difficulty participants had with envisaging how, and having conviction that, therapy would help them. The overarching theme, *Being helped to heal myself*, describes how participants sought a sanctuary of acceptance in order to talk about and ultimately self-manage their problems. The final overarching theme, *How to deal with my depression*, highlights the way participants conceptualised solutions to their depression. A central theme about the prospect for change appears to be mediated by issues of identity, capability and responsibility. The study has implications for how mental health services and practitioners engage with people with depression, and how Counselling Psychology meets its wider obligations to marginalised groups.

Introduction

Overview and Literature Review

The literature review aims to explain what is understood, from the existing research base, about the experience of help-seeking and expectations for therapy in people who are depressed-

A number of facets of the research into depression, such as its definition, aetiology, prevalence and treatment are briefly examined for the purpose of providing context to more experiential perspectives in relation to help-seeking and expectations for therapy.

The conceptualisation of depression in the research literature will be examined to try to understand why there is a research focus which is especially concerned with treatment outcomes.

The help-seeking literature might serve as an attempt to identify factors, other than those related to treatment efficacy, which affect the likelihood of contact being sought with mental health professionals. It is also believed that an understanding of the help-seeking behaviours of individuals with depression could facilitate a more comprehensive notion of expectancy.

The common factors model is explored as the basis for understanding the importance of individual or subjective factors which affect how individuals with depression face the prospect of therapy. The limited research in this area is then considered.

The Concept of Depression

The bio-psychiatric conceptualisation is the dominant model of depression and it tends to eclipse other models (Lewis, 2012). There is an inherent idea that depression is a healthcare problem and therefore this is the only route by which people can receive help. It therefore follows that the biologically derived position that depression is caused by a “chemical imbalance” is often echoed by the layperson. This idea rests on the monoamine hypothesis of depression which posits that the levels of the dopamine, serotonin, and norepinephrine neurotransmitters in the brain are suppressed. The explanation which gained momentum in the 1960’s and 1970s, appears to enjoy wide acceptance amongst clinicians even though research has failed to consistently validate the concept (Delgado and Moreno, 2006).

Alternative biological approaches exist, such as the damage and impaired healing hypothesis which contends that stress-induced changes cause damage to neurons and supporting glial cells that are resistant to the process of neuroplasticity, particularly in the frontolimbic area (Pittenger & Duman, 2007).

This converges with psychosocial explanations which might suggest that those with poor life and coping skills are more vulnerable to stress, and therefore depression (Williams and Neighbours, 2006). The role of family background, including exposure to stress and trauma, has been extensively studied in this regard (Bernet & Stein, 1999; Goodman & Gotlib, 1999; Shiner & Marmorstein, 1998; Toth *et al.*, 1992). The stress-diathesis (Schott *et al.*, 2006) variant of the biopsychosocial model of depression treats all of these as contributory risk factors, and yet the means by which they interact remains poorly understood (Engel, 1978; Garcia-Toro & Aguirre, 2007).

The social constructionist perspective considers how depressed individuals themselves describe and account for their depression, with the view that this explanation has been shaped by their social and cultural context, affecting how they relate to and experience their emotional state (Kemper, 1981). In contrast with the positivist conception that holds depression as an objectively defined and measurable pathology or mind illness, social constructionists say that this emotion is a part of the natural range of sadness and misery which the experiencer is made to believe is abnormal or unacceptable (Ussher, 2010). In this explanation it is not the intensity of the emotion that is misplaced but rather something unhelpful in the experiencer's life, such as an inescapable financial or relationship strain.

Other non-biological models of depression include psychological, family and spiritual models (Lewis, 2012).

Psychological Approaches to Depression

A number of psychological explanations for depression exist and the cognitive-behavioural, person-centred, psychodynamic and interpersonal ideas are introduced here.

The cognitive-behavioural model of depression focuses on how a person's pattern of thoughts and behaviours could have contributed to their low mood. It was developed out of Beck's conception of negative distortions in what is referred to as the cognitive triad; these are distorted cognitions about themselves, the world around them and their future (Westbrook *et al.*, 2011).

The person-centred model of depression is concerned with what is influencing the depressed individual's actualising tendency, that is, their drive to sustain and improve themselves (Sanders & Hill, 2014). This approach might therefore focus on what emotional needs motivate the person in their present situation, highlighting any discrepancies between their perceived self and experience.

Psychodynamic theory holds that depression results from introjected anger from the loss of an important "object", such as a significant other person (Newman & Hirt, 1983). The avoidance of painful emotions, including feelings of worthlessness and inadequacy, the role of early life experiences and conflicts around needs may contribute to low mood (Mauck & Moore, 2014).

Interpersonal therapy considers how an individual's depression occurs in the context of relationships which may be affected by and affecting this experience, and consequently importance is placed on becoming more aware in and changing these relationships (Klerman & Weissman, 1994).

Research Methodologies in Depression

As is evident from the range of approaches to depression outlined above, what constitutes a person being depressed varies considerably, and this is important in determining the epistemological and methodological stance in research into the subject. Biological and cognitive-behavioural explanations are more likely to be examined through the positivist assumption that knowledge can be discerned objectively, and therefore tends towards more quantitative forms of investigation and testing hypotheses through statistical analyses. By contrast, socio-psychological explanations such as the person-centred and interpersonal explanations are concerned with the personal and social experiences of participants, and tend toward more qualitative forms of investigation which may try to establish and interpret meanings captured in naturalistic verbal reports (Smith, 2008). The types of questions which might be asked in relation to the study of depression depend on the particular methodology adopted (see also Eatough, 2012, p.337). Examples are presented in Table 1 below.

Table 1: Methodological Approaches and corresponding research questions

Methodological approach	Example of research question
Quantitative	Does the negative cognitive bias in depression affect outcome expectancies in therapy?
Qualitative	

<ul style="list-style-type: none"> ▪ Thematic Analysis ▪ Interpretative Phenomenological Analysis ▪ Grounded Theory ▪ Discourse analysis 	<p>What are depressed people's expectations for therapy?</p> <p>How do people make sense of their experiences of receiving help for depression?</p> <p>How do depressed people's help-seeking beliefs influence their decision-making?</p> <p>How do people talk about and negotiate the process of receiving help for depression?</p>
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Diagnosis

The Diagnostic and Statistics Manual 5th Edition (DSM V, 2013, p.160) criteria used in the diagnosis of a Major Depressive Disorder (MDD) indicates that there must be either depressed mood or loss of pleasure, plus a minimum of four other symptoms such as changes in weight or sleep, and psychomotor activity, fatigue, feelings of worthlessness or guilt, loss of concentration, and thoughts about death.

The DSM diagnostic categories have come under considerable scrutiny, and no less so for reliability issues, e.g. MDD was found to have a Kappa reliability statistic of 0.28 (Freedman *et al.*, 2013). This might explain why, since 2009, the National Institute of Clinical Excellence (NICE, 2011) guidelines go beyond the diagnostic criteria in recommending access to services for people with persistent sub-threshold symptoms of depression.

Prevalence of Depression

In 2004, the WHO estimated that 121 million people worldwide have depression and their assertion that its incidence is growing has been supported by more recent studies (Horwitz and Wakefield, 2007; NICE, 2011). Rihmer and Angst (2009) determined that the lifetime prevalence of depression – that is, how many people who will get depression over the course of their lifetime – in the United Kingdom and other western countries is between 5-17 %. Women are understood to be twice as likely as men to have depression (Piccinelli & Wilkinson, 2000).

Treatment of Depression

The NICE guidelines were introduced in 2003 and revised in 2007, and include a quality standard which was introduced in 2011. In England, an Improving Access to Psychological Therapies (IAPT; Turpin *et al.*, 2006) service assessment determines the intensity of the intervention, according to a stepped-care programme. Interventions typically range from guided self-help, psycho-education and physical activity groups at one end of the spectrum

to combined treatments involving high-intensity psychological therapy, and anti-depressants at the other.

Outcomes for Depression

In general terms, interventions for common mental health problems which come under the IAPT umbrella have been shown to yield positive outcomes (De Lusignan *et al.*, 2011; Parry *et al.*, 2011). That therapeutic interventions can yield positive outcomes for individuals with depression does not appear to be contestable (Cuijpers *et al.*, 2008; Robinson *et al.*, 1990; Steinbrueck *et al.*, 1983). Therapeutic approaches, including those underpinned by cognitive, interpersonal, and behavioural models, have been shown to have empirical support (Chambless & Ollendick, 2001),

Some individuals with depression do not benefit from interventions and are consequently labelled as being treatment resistant (Schlaepfer *et al.*, 2012). There is a growing momentum to understand what is normally seen as treatment resistance as an inadequacy in the quality of the interventions delivered (Sackeim, 2001; Souery *et al.*, 2006).

The Experience of Depression

Addis and Carpenter (1999) proposed that patients' beliefs about the causes of their depression can be complex and may well be conceptually relevant to the process and outcome of therapy, and it is axiomatic that a more subjective approach is needed to capture these (Granek, 2006).

Phenomenologically, depression stands out as being an incredibly painful experience that is easily misunderstood, sometimes because it seems so at odds with a person's life circumstances, and because it is so distressing for others to see. Hammen (1997) says that the occurrence of depression conflicts with societal expectations that people should have control over their emotions. Depression can be experienced as isolating, particularly since it may be accompanied by a lack of sympathy from others. People may end up feeling the individual's sense of hopelessness and the common metaphor of being trapped is a manifestation of this (Emslie *et al.*, 2006).

Rhodes and Smith's (2010) phenomenological study captures the dread of loneliness and its relationship to dying for one depressed individual. This disconnectedness (Midgley *et al.*, 2016) can also be experienced along with feelings of rejection and of being misunderstood, making it difficult to feel like they could participate in society on an equal platform (McNair

et al., 2002), with implications for one's sense of self because of the way in which we define ourselves in relation to others (Granek, 2006).

Some become swamped by their self-loathing in a way that leads them to confess their sins, berate themselves for the ills that they have committed, and assume responsibility for everything that has not been successful in their life (Lewis, 2012), culminating in feelings of anger towards themselves and others (Midgley *et al.*, 2016). In contrast, accomplishments are forgotten or minimised and it is not surprising that people with depression might have such a bleak view of what is in store for themselves (Midgley *et al.*, 2016). Hamman (1997, p.37) stresses that this is not, 'a failure of willpower and motivation'. Rather the weight of the depressed individual's troubles can lead to questions about the purpose of their own existence, and thoughts of death can provide a release from their pain. This view is consistent with Rhodes and Smith's (2010) depiction of the personal hell and suffering of an individual who reported a fear of being attacked at every moment and of being suffocated by his own experiences. Feelings of guilt and shame can mean that people distance themselves from others who can potentially offer help.

There is little evidence in the research literature of an attempt to try to understand how people's experience of the condition effects their help-seeking behaviour and expectations for therapy.

Help-seeking Challenges

Despite the evidence that therapy is an effective way of helping people with depression (see Lambert & Bergin, 1994), there is a well reported gap between those needing help and those seeking help from mental health services (Mojtabai *et al.*, 2002). In a study by Roness, Mykletun and Dahl (2005), rates of help-seeking were found to be extremely low and only 13% of people with depression, compared with 25% of those with anxiety, had sought help from a mental health professional. This is an important statistic given that the experience of help-seeking often encourages a positive attitude toward further help-seeking (Halgin *et al.*, 1987).

Saunders (1993) found that people normally try to heal themselves before going for counselling, which is regarded as a last resort. This is supported by the finding that severity of condition is associated with an increased likelihood of help-seeking (Horenstein, 1975; Motjabai *et al.*, 2002). Horenstein (1975) found that people anticipated a need for therapy specifically when they experienced an intolerance of uncertainty about their future, which

is more closely associated with anxiety than depression (Dugas *et al.*, 2004). This may explain why therapy is significantly less likely to be sought by individuals with depression.

To try understand more about the factors which affect help-seeking, Manthei (2006) asked participants to express themselves freely about their experience of seeking counselling and their decision-making rationale in his qualitative study. The decision to take up counselling was found to be motivated by: their own strategies (e.g. reading self-help literature) being ineffective and wanting to try an alternative approach; a crisis event occurring; following up advice or a recommendation; having had previous experience of counselling. A significant limitation of Manthei's study was the sample, which was comprised mainly of women. Perhaps this is to be expected given that women are more likely to have depression (Van de Velde *et al.*, 2010), and commit to therapy for it (Churchill *et al.*, 2000; Dwight-Johnson *et al.*, 2000; Parker & Crawford, 2009).

Taylor and Loewenthal (2001) discussed a range of factors that affect how individuals approach the idea of seeking therapy, including cultural influences which, for example, make it taboo, not believing that anything can help, not being able to discuss the issues, and individuals believing themselves to be a burden. It follows that that these culturally based preconceptions could produce fairly negative expectations for therapy.

Barney and colleagues (2009) reported focus group discussions about the stigma relating to the experiences of people with depression and their help-seeking. Stigmatising beliefs expressed by others – such as they are responsible for their own condition, they are unlikable and present a threat – were accompanied by concerns about employers knowing they were seeking help from mental health professionals. McNair and colleagues (2002) contend that healthcare professionals are as likely as the wider public to express stigmatising attitudes, presenting a significant barrier to those seeking help. This may be compounded by the negative attitudes that people with emotional distress themselves may have towards their own mental health (Pill *et al.*, 2001), potentially reflecting some internalisation of the stigma described above.

In addition to the longstanding view that depression results in a negative bias in cognitive interpretations, individuals with depression are more likely to tune into negatively-oriented items of information (Lawson & MacLeod, 1999), such as the cultural preconceptions and stigma identified in these studies. Yet clients often know what is wrong with themselves on some level and what they expect to need to focus on in terms of their psychological origins (Howe, 1993). Prospective clients with depression might therefore perceive a tension

between other people's views, which are feared to be negative, and a need to help themselves through therapy. In Taylor and Loewenthal's (2001) discourse analysis of an individual case, these concerns led to thoughts of inadequacy and self-doubt. Incidentally, this may reflect the finding that people who refrained from disclosing their low mood alluded to others making attributions about their strength and coping (Williams & Healy, 2001). Seeking reassurance was seen as an attempt to mediate expectations that undertaking a course of therapy would expose them, thus revealing their "madness". Help-seeking experiences and the development of expectations for therapy would be appear to be intertwined in this way, and this is further evidenced in Johnson and colleagues' (2011) study which examined men's help-seeking in the context of stigma. It identified discourses around seeking help such as taking responsibility, being self-reliant, needing to protect their vulnerability, desperation around their need for help and the need for a genuine connection with the helper. Other research reveals that these findings may not be so gender-specific (Emslie *et al.*, 2007).

The need for mental health services to be sensitive to these issues is highlighted by the finding that negative attitudes and expectancies about treatment contribute to the underutilisation of services (Clement *et al.*, 2015; Pill *et al.*, 2001; Stewart *et al.*, 2014). Such research indicates that an individual's perception of services was the most common barrier to the use of mental health services. Other research has highlighted the issue of inadequate treatment contributing to reduced levels of help-seeking (Lecrubier, 2006).

Common Factors Model of Therapy

Lambert was interested in understanding what contributes to psychotherapy outcomes and his seminal studies identified factors in four categories (the amount of outcome variance accounted for is reported in brackets; Lambert & Bergin, 1994): the model and techniques used in therapy (15%); client variables (40%); the therapeutic relationship (30%); expectations for therapy (15%).

The vast majority of studies into therapy aim to assess the efficacy of particular modalities of therapy under different conditions (Lambert, 1992). Whilst the therapist's theoretical model is important, a significantly greater proportion of the outcome variance could be said to be determined by factors that are present in all types of therapy, irrespective of the "brand".

This assertion is supported by several arguments. Firstly, evaluations of the efficacy of different therapy types are often contradictory across a range of studies, with some in favour of one approach and others in favour of another. Secondly, the so called “Dodo bird conjecture” postulates that, upon comparison, differences between therapies do not exist. Meta analyses comparing the efficacy of different therapeutic interventions appear to provide support for this argument (Cuijpers, 2008; Wampold *et al.*, 1997), and small differences in efficacy may be better explained by theoretical bias or “allegiances” (Robinson *et al.*, 1990, p.31). Consequently, Lambert (1992) argues that it is incumbent upon therapists to make the most of the therapeutic gains which can be made through the so-called common factors. Expectancy has received the least attention in research out of all the common therapeutic factors (Patterson *et al.*, 2008; Weinberger and Eig, 1999; Westra *et al.*, 2010).

What are Expectations?

Expectations are one of many pre-treatment client characteristics, which are those psychological elements which they take to the first therapy session (Dew & Bickman, 2005). Junker (2000) says it involves having a knowable “vision” of ourselves in a particular context which might draw on the past: “the speaker has evidently laid out some image of himself that awaits him in the future” (p.697). A more specific definition of expectation in the context of an individual facing therapy is provided by Nock and Kazdin (2001): “anticipatory beliefs that clients bring to treatment and can encompass beliefs about the procedures, outcomes, therapists, or any other facet of the intervention and its delivery” (p. 155).

The earliest research into expectations for mental health treatments derives from research understanding the so called placebo effect (Rosenthal and Frank, 1956). According to the placebo effect, having belief in the success of an intervention makes it more likely that it will be successful (Colloca *et al.*, 2014).

Perhaps surprisingly, this psychological phenomenon has been explored far more extensively in relation to pharmacological solutions to health issues than it has for therapeutic interventions for mental health issues (Shapiro & Shapiro, 1997). For example, in Rutherford, Wager and Roose’s (2010) review of antidepressants for Major Depressive Disorders, the placebo effect could sometimes yield a rate of efficacy that was larger than the difference between placebo and the drug being trialled. This could be taken as indirect evidence of a positive relationship between client expectations and outcome. They

concluded that more positive expectations for the treatment were related to better clinical improvements, and therefore interventions could be oriented to benefit from this.

Research has demonstrated the action of positive expectations for therapy in people with depression (Meyer *et al.*, 2002).

Expectation could be seen to be important from an intuitive point of view, for example, that clients believe in the utility of therapy and in seeing a therapist. Frank (1974) suggests that this might be referred to as having faith or hope that therapy will be successful.

Expectancy is difficult to distinguish from hope, since it might be a part of it, as can be observed from this definition of hope: 'a wish or a desire for something accompanied by an expectation of or belief in obtaining it' (p.23). Expectation and hope can be disentangled in the sense that expectation can exist in the absence of hope. Research has also shown expectations for therapy to be distinct from perceptions, preferences and counselling readiness (Patterson *et al.*, 2008), and perceptions of credibility for therapy (Schulte, 2008).

The focus on client expectations has been concerned with factors which affect clients' abilities to actively engage with the therapy, including their willingness to participate and their openness to therapists' influences (Glass *et al.*, 2001). As McLeod (1990) suggests, one of the principle themes in a client's experiences of therapy is their perceived ability to become a client. This suggests that expectations could potentially have a powerful part to play in a person's ability to develop a sense of self-efficacy around the use of therapy to meet their objectives. Knowing a client's expectations for therapy therefore help therapist know how they might best socialise them in preparation for the support they will receive (Patterson *et al.*, 2008).

Other than 'correcting' clients' misconceptions for therapy, understanding clients' negative expectations may have other important benefits for therapy. Weitkamp and colleagues (2017) argue that negative expectations can provide a cue for the therapist to offer Bion-esque containment, that is, to take in what the client perceives to be unmanageable and make it more manageable for them. Gabbard (2010) discusses how negative expectations for therapy can reflect therapy-relevant material, such as the client's fantasy life: how they wish for some outcome but then modify their action in anticipation of a painful response from another. Uncovering the details of the fantasy may therefore provide rich information for the formulation, such as this type of role-conflict which may serve to protect a client from psychological harm.

Therefore, as understanding expectations can provide useful information to the therapist they are clinically relevant (Dew & Bickman, 2005). Client and therapist expectations have long been understood as having influence in the course of therapy (Duckro *et al.*, 1979). Indirect evidence comes from the finding that clients who have experienced therapy as successful return to therapy more quickly and with less anxiety (Manthei, 2006).

The Impact of Expectations (the Positivist Stance)

Since Goldstein's (1962) seminal review of the expectation studies, research has investigated the degree to which the expectations of individuals seeking therapy affects the process and outcome of therapy. The principle means of studying expectancy has involved a quantitative methodology. Many studies have contrasted the scores of participants' ratings for how they felt prior to therapy and how they thought they would feel after therapy, i.e. the anticipated benefit from the therapy. These would be juxtaposed with the actual scores obtained following the course of therapy. Typically this has been achieved using questionnaire measures, examples of which include the *Psychotherapy Expectancy Inventory* (Benzins, 1971) and *Expectations about Counselling* (Tinsley *et al.*, 1980).

Two major studies sought to examine the outcomes of research into expectations about therapy. Greenberg, Constantino and Bruce's (2006) review of the expectancy literature identified discrepant results for the association between treatment expectations and process, and between treatment expectations and outcome, particularly for role expectations (see also Duckro *et al.*, 1979). A review of studies about clients' expectations by Glass, Arnkoff and Shapiro (2001) similarly failed to find an effect for role expectations. This review of 24 studies conducted between 1956 and 2000 also revealed mixed support for a correlation between expectations for therapeutic gain and outcome. Both studies found improved support for the impact of some types of expectancy, albeit from a limited number of studies.

In terms of expectations for therapeutic outcome, Greenberg *et al.* (2006) reported that expectations about therapy duration were shown to relate to how long therapy lasts. Callahan, Aubuchon-Endsley, Borja and Swift (2009) carried out research which suggested that up to 14% of the outcome variance in premature terminations was explained by clients' expectations.

Process expectations such as feelings of comfort and active involvement have been shown to correlate to improved outcomes (Greenberg *et al.*, 2006). Glass *et al.* (2001) cited

significant research support for the effect of pre-therapy expectations on working alliance, as an intermediate outcome (i.e. it develops during therapy), and this finding has been consistent in recent studies (Gibbons *et al.*, 2005). Incidentally, they argue that this potentially identifies working alliance as a mediating factor, since it has itself been established to be a strong predictor of therapeutic outcome (Lambert, 1992). Patterson, Uhlin and Anderson (2008) explain this in terms of expectations about personal commitment. Clients who expect themselves to be motivated and to engage with therapy by being open and available fulfil these expectations through a collaborative and fulfilling relationship with the therapist.

A small amount of research has examined what happens when expectations are disconfirmed, i.e. expectancy violations. Patterson, Uhlin and Anderson (2008) found that the disconfirmation of negative pre-therapy expectations were associated with good outcomes and better than expected improvements.

It follows that negative expectations that have not been addressed foster poorer performance, and this has ample research support (Suhr & Gunstad, 2002). This might be a considerable barrier to successful outcomes in depression, given the tendency towards feelings of hopelessness that are commonly associated with it. Since Reis and Brown's (1999) study suggests that differences between the therapists' and the clients' expectations can be responsible for untimely endings, there appears to be a stronger argument for understanding and working with clients' expectations, be they positive or negative.

The evidence that expectations affect the outcome of therapy for individuals with depression is limited. Ilardi and Craighead (1994) found that for depressed individuals, most improvement in Cognitive Behavioural Therapy (CBT) occurred in the fourth session, before the process of cognitive restructuring had gained momentum. Along with a number of other non-treatment factors, expectancy was found to significantly influence therapeutic outcome, accounting for up to 40% of the variance.

More recently, Tsai and colleagues (2014) examined expectations for group CBT, finding that severity of depressed symptoms predicts outcome expectancies. They also found that expectations affected therapeutic alliance in the early phase of the intervention, while expectations captured at this stage affected the alliance mid-therapy and outcomes, the more positive expectations yielding improved outcomes in their quality of life and

interpersonal relating. Improved expectations were associated with better outcomes, however the authors indicate there was considerable variability in this.

The principle criticisms that have been levelled at expectancy studies concern study design. Many of the studies examined in these reviews lacked methodological rigour: some used poorly operationalized variables (Duckro *et al.*, 1979); many have relied on anecdotal report or the use of continuation in sessions as an outcome (Glass *et al.*, 2001); most are quantitative studies reliant on self-report using rating scales, only allowing participants to respond within predefined categories (McLeod, 2001). Arguably, questionnaires which focus on one or two aspects do not capture the client's perspective well (Manthei, 2006). Moreover, it has been suggested that often the measurement tools used have not been psychometrically tested (Dew & Bickman, 2005).

A final point about the quantitative research reviewed is that it has not established a causal link between client expectations and any quality of therapy (Glass *et al.*, 2001). This may point to the failure of what Graneck (2006) refers to as the objective approach to depression, which holds that depression is something that can easily be rid of as long as testable standards are adhered to. The volume of research attests to the greater prominence enjoyed by the positivist stance.

The Need for a Qualitative Perspective (the Subjective Stance)

Contrary to the positivist position described above is the subjective stance, which gives importance to and focuses on aspects of an individuals' perception and experience, which may be obtained by participants through personal reflection and insight.

By studying client experiences through qualitative interviews the researcher can learn how events that they have been through are understood, this perspective being delivered from their own words. Another argument for the importance of the contribution of qualitative accounts in this area is articulated by Manthei (2006). The author says that obtaining an in depth account from clients is useful since they do not reveal all of their thinking processes to therapists, and because clients' and therapists' thinking about the therapy often differs.

The findings from qualitative research are extremely limited. Maier and Straub (2011) interviewed migrants who had suffered trauma about their treatment expectations. In addition to presenting with a sparse knowledge of therapy, they also reported more negative attitudes towards it compared with medical treatments, despite conceptualising their illness as being a result of a series of stressors (i.e. non-mono-causal) and having an

awareness of the psychosocial factors underlying their concerns. The authors considered that this reflected passivity towards their treatment. They also found that participants' experiences were so extreme that they could not account for them using their usual socio-cultural frames of reference, and consequently, their treatment was perceived as an opportunity to attend to this crisis of identity by redefining themselves. Methodologically this research appeared to be limited by a poorly demarked qualitative approach which employed the unorthodox approach of using questions to establish *a priori* themes (Braun and Clark, 2013).

Westra and colleagues (2010) explored clients' accounts of discrepancy between their expectations and their actual experiences of CBT. Those who experienced good outcomes identified disconfirmed negative process expectations, such as: it will not be collaborative, there will be an absence of opportunities for control, and the degree of discomfort will high.

Lewis (2015) similarly compared expectations and experiences of therapy using a hermeneutics framework. His study identified themes around the role of the therapist as an expert leader with the responsibility of "fixing" clients, the need for a collaborative facilitator who welcomes client influence, and the challenging nature of achieving a sense of empowerment in the therapeutic process. The research underlined the importance of clients' experience of contracting, directiveness, engagement and alliance in relation to their initial expectations. It also highlighted a need for there to be more explicit awareness of power in the therapeutic alliance. The research was limited to clients being seen by relational therapists who did not practise CBT, and by the researcher's own declaration, potentially predisposed participants to report expectations that were not subsequently met. It is nevertheless, supported by findings elsewhere (Paulson-Karlsson and Nevenon, 2012) that people in therapy expect a collaborative relationship that helps them make progress toward their recovery.

The only known qualitative research that specifically examined depressed clients' expectations for individual therapy was based on a sample of young people (Midgley *et al.*, 2016). Their expectations for therapy revealed that they intuitively saw talking as means by which they would be helped in therapy, and saw a professional (distant even) relationship as being facilitative to this. In common with the studies by Maier and Straub (2011) and Lewis (2015) described above, participants had difficulty generating specific expectations (curiously, even though some participants had previously had therapy), saw the therapist

as the expert healer and sought to redress concerns relating to their identity, albeit by recovering their old selves or discovering new capabilities. The authors captured how young people wanted therapy “to take away something painful” and in this way expressed some hope of change occurring. Potentially influencing this research, participants were also involved in a clinical trial which may have positively influenced their expectations of recovery.

A significant limitation of the qualitative studies captured above, in the areas of help-seeking and expectancy, is that typically clients had already begun or completed their course of therapy when their pre-therapy expectations were sought (Dew & Bickman, 2005). It is plausible that their experience of therapy influenced their retrospective perceptions (see Manthei, 2006). Many studies did not exclude those with previous experiences of being a client, potentially lending some bias to their expectations. Their experience is likely to be different from those who have made the decision to see a therapist for the first time. McLeod (1991) states that pre-therapy clients provide practitioners with a view of their experiences that is raw and unencumbered by the language that therapists use to understand their clients conditions. He argues that the clients’ perspective is “decentering” for therapists since it does not have a theoretical frame, and this allows them to get closer to the clients experience.

Some studies have served to address this issue. Beattie and colleagues (Beattie, Shaw, Kaur & Kessler, 2009) conducted pre and post interviews with clients receiving online CBT to understand their therapeutic experience. The study underlined the importance of establishing client fit and preferences for this particular mode of delivery.

Young people were interviewed immediately prior to their first session, in a study by Watsford, Rickwood & Vanags (2013), to understand their reluctance in help-seeking. Participants expected to be ready for therapy and to talk through their concerns. They considered their therapist in terms of likeability and directiveness. Participants were hopeful, typically expressing non-specific positive outcomes. The research further highlighted the issue that poorly informed clients were likely to present with unrealistic, and therefore unmet, expectations. Again, the themes identified appeared to be limited to categories predefined by their questions. The research potentially lacked depth since interviews were reportedly short, which may partly reflect the issue that some participants felt that they had been coerced into therapy.

Tambling, Wong and Anderson (2014) examined expectations for couples counselling prior to the first session, with their software aided analysis also yielding themes that appear to reflect their categories of questions, but nevertheless providing some interesting findings. Expectations for the therapist were influenced by media depictions (see also Orchowski *et al.*, 2006). They expected to discuss issues at depth, with this being facilitated by the therapist's questions. The therapist was anticipated to provide perspective, and be potentially uncomfortable. They also expected to draw connections between their personal histories and their present difficulties. The authors concluded that these pre-counselling clients had formed firm expectations and that therapist should be inquisitive about these at the outset.

The Present Study

Robinson and colleagues (1997) asserted that if we are to understand how therapy helps clients then expectations, as one of the common factors, should be more of a focus for research. The evidence suggests that this could have positive implications for service use. Beyond this, it is surprising to learn that client expectancies are not addressed in the training of any division of therapy (Weinberger and Eig, 1999), which could be symptomatic of both the small amount of significance and understanding attributed to the utility of exploiting this non-specific factor in therapeutic practise.

There is sufficient research to suggest that expectations are an important consideration in relation to an individual's experience of therapy. Greenberg, Constantino and Bruce (2006) indicate that this is likely to be under-acknowledged, but concede that limitations in the existing research suggest a need for improved methodological design. Simply put, there is a lack of robust research which explains the relationship between pre-therapy expectations and therapy outcome (Dew and Bickman, 2005; Suhr & Gunstad, 2002). There is also reason to believe that expectations are more diverse than existing, mainly quantitative, research suggests and that this is an effect of overly-structured and restrictive measurement approaches (Gladstein, 1969).

Expectations can be changed (Weiner, 1985), and as with all of the common factors, this is a means by which therapists can expect to improve their therapeutic practise (Lambert & Bergin, 1994). The basis for clients' prognostic expectations for therapy and their openness to exploring these should be important aspects of the therapeutic approach. Overall research suggest a probable role for 'maximising perspective convergence' (Reiss & Brown, 1999, p.123) between the clients' and therapists' expectations.

While the research suggests there is a case for managing expectations for therapy, including cases involving depression, the associated advice appears to appear as an afterthought (Robinson *et al.*, 1990) and often tend towards generic statements. These include creating positive expectations by presenting the evidence base and identifying any discrepancies that clients may have about the length and content of therapy. This approach would fit with Bandura's concept of self-efficacy, that is, the way a person's confidence in their ability can be developed to meet their objectives (Bandura, 1997).

A qualitative approach is well positioned to improve our understanding of the complexities relating to the matter of how expectations for therapy may be understood and worked with. A critical examination of the limited body of research to date highlights the reliance on a retrospective methodology. The results present expectations that could have been influenced by the participants' subsequent experience of therapy, and in some cases, previous experiences of therapy too, and are likely to be subject to a distortions in recollection.

As Rhodes and Smith (2010) suggest, given the vast amount of research that has been conducted on depression, few studies have attempted to obtain a phenomenological understanding of the condition. It is perhaps for this reason that very little is known about the expectations that people with depression have for therapy. They suggest that there is a danger of bracketing clients who have depression using generalist stereotypes.

Research has not adequately explored what kind of expectations it might be useful to respond to in adults with depression. This notion accords with the idea of cognitive specificity, which says that each mental health condition is associated with a specific set of cognitions. The way that depression is understood as a condition suggests that it may present a specific type of challenge with regard to managing expectations, which may relate to negative perceptions of themselves, their environment and their future (Blackburn & Twaddle, 2011).

For the purpose of gaining an understanding of these expectations to any degree of depth, it would seem to be difficult, and counterproductive even, to try to untangle them from the individuals' perception of their difficulties, and any help-seeking attempts that they have already made to remedy these (Tsai *et al.*, 2014). It is likely that some preconceptions are likely to also be enmeshed with ideas about their condition and help-seeking that are socio-cultural in origin.

Importance to Counselling Psychology

The British Psychological Society's Code of Human Research Ethics (2011) states that research involving people should have purposeful benefits. It is argued that this study makes the following specific contribution to field of Counselling Psychology:

1. Existing understanding of expectations derives from a quantitative approach that presupposes the types of expectation that clients have about therapy, with a heavy focus on outcomes. A qualitative approach allows us an opportunity to adopt a more holistic perspective about expectations, in the context of the individual's experience of their mental illness. This is more compatible with the person-centred foundations of counselling psychology (Cooper, 2009).
2. Trying to understand the clients we work with is an ethical imperative (BPS, 2006; HCPC, 2008). As McLeod (2001, p.41) says, it is a 'reminder to therapists of what it is like to be in the other seat'. To hear the voice of people who have never been in therapy and are not responding to a particular therapeutic framework can be 'decentring' for therapists. Counselling psychology is a values-based paradigm (Division of Counselling Psychology, 2005) and the research could further our ability to learn about our clients' personal values for themselves.
3. Lambert's (1992) seminal research into common factors expectations are a significant predictor of therapeutic outcome; it is hoped that the research will improve our understanding of how expectations can affect a client's prospects for therapy, in the context of existing theories of depression.
4. Client expectations are likely to link to their motivation for and knowledge about the therapeutic process. Improving clients' readiness and motivation for therapy could be regarded as an important aspect of a therapist's work with their client (Prochaska *et al.*, 1992; Rollnick *et al.*, 2008).
5. The most critical improvement comes from early response in therapy (Haas *et al.*, 2002). Understanding where clients might be coming from the outset would seem to have usefulness (Bevan, 2009). Clients can be reluctant imparters of information (Jinks, 1999), particularly at the beginning of a relationship with a therapist. Holmes (2001) explains that clients can be desperate to share their material but terrified of intimacy until the attachment to the therapist is sufficiently secure.

6. The quality of the therapeutic relationship (or working alliance) is widely understood to be predictive of therapeutic outcome. Learning about individuals' help-seeking expectations could potentially contribute to the knowledge of transference in the therapeutic encounter.
7. It is important to recognise that some people with depression have not referred themselves for therapy. Understanding client expectations will alert us to potential client needs. Therapists have a significant role in empowering clients by supporting their right to autonomy.

Methodology

Aims and Rationale for the research

This study aimed to gain a better understanding of how people with depression think about therapy and how it might help them. Most studies about client expectations are grounded in a quantitative approach, and this body of research has yielded inconsistent results. There is very little research which addresses this question from a phenomenological perspective and no research which is concerned specifically with expectations for therapy in adults with depression. The specific presentation associated with the onset of depression, such as negative appraisals, hopelessness, feelings of worthlessness, guilt and shame, would appear to have implications for their capacity to enter into and benefit from a helping relationship. This research, which is centred around the client's subjective perspective, was intended to help us to understand more about how prospective clients think about their impending journey into therapy, and what aspects of this that they focus on.

The study uses a qualitative approach to explore the following issues:

1. How do participants view their depression? What does it mean to them? It is hoped that this will provide some context to what they understand about their help-seeking behaviour and their expectations for therapy.
2. What did clients' experience leading up to, and in the course of making, the decision to take up therapy?
3. What do individuals with depression expect to occur in therapy? What do they expect to get out of it? This might include, for example, expectations about: the therapist; the helping relationship; how they might change - in their sense of self, in relation to their depression and in relation to others.

Design

The body of existing research on clients' expectations has been performed from an objectivist or positivist stance and it has produced inconclusive findings. McLeod (2001) criticises the use of quantitative approaches since participants' self-reporting is often limited to responding within predefined categories, sometimes using rating scales. The rationale for self-report methods in a qualitative approach is explained in simple terms by Barker, Pistrang and Elliot (2002, p.94): 'When you want to know something about a person, the most natural thing is to ask'. Self-report methods enable researchers to directly

access the phenomenological perspective which is vital to gaining an improved understanding of the expectations of clients-in-waiting who have depression. The aim of the research interview in this qualitative study was to elicit the participants' own frames of reference in relation to this topic. Wilkinson, Joffe and Yardley (2004) suggest that it is less likely that the researcher's own beliefs and assumptions will become prohibitive to this goal if they are able to show that they are good listeners, are empathic, can encourage the participant to express their worldview and facilitate discussions about feelings. Given the sensitive nature of exploring a mental health related topic these qualities would seem highly relevant, and potentially makes a therapist well suited to the task of conducting this research (McLeod, 1999). The interviewer is given the opportunity to build up a rapport with participants. Using this interpersonal context, the researcher can explore in depth the participants' experience of having depression and seeking help from others, the meaning attributed to these experiences, and the implications that these will have for their expectations for therapy.

The flexibility of the semi-structured interview means that it is possible to probe beyond the more superficial answers that participants may initially respond with. Additional questions can be spontaneously tailored to the information brought by participants, adding to the process of sense-making around the issues in question (Wilkinson *et al.*, 2004). In this way participants can be supported to give fuller accounts and use the opportunity to tell their story, fulfilling the potential of the interview as a narrative process (McLeod, 1997) – for it is this that reveals their 'psychological reality' (Smith, 1995, p.10).

The transformation of Thematic Analysis (TA) from a catch all for qualitative approaches not categorised as one of the "branded" approaches (i.e. Grounded Theory, Interpretative Phenomenological Analysis (IPA), and Discourse or Narrative Analysis) into a systematic procedure in its own right can be attributed to the landmark work by Braun and Clark (2006). They outline a method of organising and analysing qualitative information according to the meaning that participants attribute to their experience. The *a priori* assumption of this particular approach is that there are commonalities in those meanings from one participant to the next, and so the data is sifted and sorted accordingly (Braun & Clark, 2012). My task as the researcher was therefore to try to make sense of the areas of shared meaning about the participants' experiences of becoming depressed, and ultimately seeking professional help for this. This process of sense-making is shared with other qualitative approaches, perhaps most explicitly so with IPA (Smith and Osborne, 2008), and falls into the realms of Heidegger's notion of hermeneutics (Packer, 2011).

TA can be distinguished from qualitative approaches which require prior theoretical understanding in order to conduct the analysis. According to Braun and Clark (2012), the main advantages bestowed by TA, that it is both accessible and has a broad range of utility, exist because it is not a complete qualitative approach. Rather it is a method of analysis following which the researcher is free to explore theoretical interpretations of the data. The analytic procedure is described in detail later in this section. Finally, TA is well suited to the task of exploring social, as well as psychological, interpretations of the data (Braun & Clark, 2013).

Epistemology

While it is suggested that TA is not theoretically driven it is also the case that the researcher needs to identify their epistemological stance on three issues before undertaking the analysis (Braun and Clark, 2006): inductive versus deductive driven data; an experiential versus critical orientation to data coding and analysis; an essentialist versus constructionist theoretical perspective.

The investigative stance was inductive, that is, the data was scrutinised for meaning using a bottom-up approach, allowing themes to be formed from semantic patterns within the data, in contrast with a top-down (or deductive) approach whereby themes are formed on the basis that pre-determined conceptual ideas need to be explored. This was consistent with the study's aim of giving a voice to participants' realities as they perceived them, and it is hoped that any assumptions about the data will be close to the meanings elicited from participants using an inductive approach.

Braun and Clark suggest that an inductive methodology is usually concerned with ensuring that the analysis represents or advocates peoples' experiences and understandings, and not with being critically interpretative. As far as is practicable, the study attempts to capture the thoughts, feelings, views and expectations of individuals, who have been experiencing depression and who made the decision to seek therapy, through their own words. That said, it would seem disingenuous to ignore the participants psychosocial contexts in trying to understand and capture their world view. In keeping with the background and aims of this study, a contextualist epistemological position was adopted as the best fit. Placed between the essentialist view that experiences as people know them are real, and the constructionist perspective that experiences are a construction of one form or another, contextual TA provides scope for this research to acknowledge the social context in which their help-seeking expectations are formed. As Rosnow & Georgoudi

(1986) reflect, people do not live in a social vacuum, and a core Counselling Psychology principle is to value understanding peoples' contexts, such as their personal histories, interpersonal lives and the society in which they live (BPS, 2005).

Ethical considerations

The British Psychological Society's (BPS) Code of Human Research Ethics (2011) provides a basis for understanding and honouring our ethical commitments to those individuals who agree to participate in research in good faith. Participants' autonomy was served through a process of informed consent. A participant information sheet (see *Appendix 2*), written according to the *Guidelines for Writing Recruitment Documents and Consent Forms* from Kings College London (2012), was sent to those expressing an interest in the research. It explained the research procedure, confidentiality, their ability to withdraw at any point and the details of services offering support. Opportunities for additional verbal explanation were provided. Participants signed to confirm that they have given their voluntary consent to take part and provided specific consent for the interviews to be audio-recorded and for their data to be used (see *Appendix 3*). Participants were alerted to their ability to withdraw their consent after they had given it, and this included withdrawing mid-interview, or asking for their data to be destroyed post-interview.

The BPS Code of Human Research Ethics imposes an ethical responsibility on researchers to protect people's right to privacy. Data was kept in accordance with the Data Protection Act (1988; see BPS Guidelines for Psychologists, 2009). Excerpts were anonymised by giving participants pseudonyms and by removing any identifying information.

There is need to try to balance the potential for the acquisition of knowledge that helps to develop psychological therapy with the potential for harm to come to the participants (Barker *et al.*, 2002). The BPS Code of Ethics in Human Research (2010) defines this risk as, 'potential physical or psychological harm, discomfort or stress to human participants that a research project may generate' (p.13). This research presented a risk that participants may experience harm in the form of psychological distress from their feelings, memories and changed sense of self as a result of their condition. To try to mediate this possibility participants were made aware that talking about their condition during the course of the interview could be distressing and that they should not participate if they thought it would significantly affect their psychological wellbeing. Participants were informed that they could choose not to answer specific questions, and were provided with information about a range of sources of support in the debriefing information (see *Appendix 5*). Also of

particular concern to this research, are the statistics which evidence an increased risk of suicide in people with depression (Haw *et al.*, 2013). To try to guard against this potentially catastrophic outcome, the suitability of participants was assessed so that those individuals who presented a heightened risk of suicide were not interviewed. Participants were therefore screened with a risk assessment procedure in advance of their participation (see *Procedure* section, below). Following the interview Barker, Pistrang & Elliot (2002) advise that participants should be asked whether they have experienced any distress as part of the debriefing procedure. If upon enquiry participants showed distress following the interview they could have been referred to their general practitioner.

Participants

Participants were a non-probabilistic, purposive sample. Inclusion criteria were that participants must be aged between 18 and 65, and were waiting for individual therapy with their main expressed problem being depression. Participants would have made the decision to go for therapy themselves, that is, they either referred themselves for therapy or were willing for the referral to be made on their behalf. Exclusion criteria were having previously been involved in therapy as a client, therapist or student, those reporting a need to be supported to communicate in English, and those with severe depression or suicidal concerns. The decision to accept only participants who could adequately express themselves in English was primarily based on wanting to obtain first-hand accounts of participants' experiences because of the importance of the meanings that they ascribe to those events. The non-inclusion of severely depressed individuals and those assessed to present a risk to themselves has been discussed in the *ethical considerations* subsection, above.

Twelve participants volunteered to take part in this study, after between 10 and 15 had been sought, which is consistent with the available guidance (Braun & Clark, 2013). The question of what is an appropriate sample size in qualitative research is ill defined, with Guest, Bunce and Johnson (2006) stating that existing recommendations lack the necessary qualifying evidence (see for example, Mason, 2010). A smaller sample was desirable because this qualitative research was concerned with the meanings underlying participants' expectations for therapy and not investigating generalisable hypotheses (Crouch & McKenzie, 2006). Ritchie, Lewis and Elam (2003) refer to the issue of diminishing returns, that is, that more data does not necessarily lead to more information. Ethically, collating unnecessary data may be wasteful of a participant's contribution (Francis *et al.*,

2010). This is intertwined with the concern that qualitative research is labour intensive, and analysing a considerably larger sample would have been time consuming and impractical given the scope of this undertaking.

Recruitment began at a third-sector counselling organisation in South Wales. It was evident that there would be difficulty recruiting those who met the specific criteria for participating in sufficient numbers. Obtaining approval from an NHS ethics board and a clinical commissioning group in the South West region allowed recruitment to continue in an organisation that was involved in the delivery of primary care mental health services. In all cases brief information was given out enabling individuals to make expressions of interest. Five individuals who initially expressed interest did not continue after having received further information about the study. In two cases this was because of their or family members concerns about their present condition.

A brief overview of the characteristics of the sample is shown in Table 1 below. Participants were eight males and four females whose ages ranged from 20 to 64 (mean age = 40.7). One participant identified their ethnicity as being Afro-Caribbean, with the remainder of the participants self-identifying as white British. Participants came from a range of socio-economic backgrounds, with five not in paid employment (one student, two unemployed, one homemaker, one retired), and seven occupied a number of different paid jobs including one who was self-employed. Participants' scores on the Beck Depression Inventory II (BDI-II) ranged from 14 to 28 (mean score= 20), which would indicate that participants had mild (scores between 14-19) to moderate (scores between 20-28) levels of depression.

Table 2: Characteristics of the participant sample

Participant pseudonym	Age at interview	Race / ethnicity	Principle occupation	Pre- interview BDI-II score
Alan	40	White British	Musical production	18 (mild)
Lisa	43	White British	Unemployed	14 (mild)

Michael	47	White British	Production manager	21 (moderate)
Emma	28	White British	Health professional	22 (moderate)
Gareth	64	White British	Retired	20 (moderate)
Adam	45	White British	Trainer	28 (moderate)
Simon	42	White British	IT consultant	14 (mild)
James	20	Black Afro-Caribbean	Student	19 (mild)
Lynda	34	White British	Homemaker	21 (moderate)
Sarah	37	White British	Finance	20 (moderate)
John	53	White British	Self-employed	25 (moderate)
Mark	36	White British	Unemployed	16 (mild)

Procedure

Individuals expressing an interest received a Participant Information Sheet, which provided detailed information about participating, and were given time to read and digest the information, and discuss it with others and the researcher if they wished. They were informed that they were under no obligation to participate in the research and that their decision not to do so would not affect their access to the therapy service. Those wishing to proceed with the interview were then invited to arrange a face-to-face meeting at a time and location convenient to them. Interviews took place at the therapy-providing

organisation (for two participants), at their home (three), at a public library (two) and at the University of the West of England (five).

Upon meeting, participants were given the opportunity to review and discuss the information about participating, before being asked to sign to confirm that they were giving their consent for their anonymised data to be used in this research study.

Prospective participants were screened using the BDI-II and the Assessment of Suicide Risk in People with Depression (from the Centre for Suicide Research). Those scoring in the “severe” range (scores >29) on the BDI or showing a heightened risk of suicide would not be eligible to participate. In consultation with one individual showing an elevated score he agreed not to participate and was given appropriate support. Consenting individuals who were eligible to participate were asked to provide some basic demographic information including their age, gender, ethnicity and socio-economic status before taking part in an audio-recorded semi-structured interview. Following the conclusion of the interview participants were asked about their experience of participating in the interview, what motivated them to participate and what they think about the research project. Time was taken to discuss the debrief information with the participants, emphasising their continuing right to withdraw their information. Participants were asked how they felt and whether they had been left with feelings of distress following the interview, with sources of support being made available through the debrief information.

The data was subsequently analysed according to the procedure identified below. A summary report outlining the results will be sent to participants who said that they would wish to receive this.

Interview Schedule

The semi-structured interview was guided by a number of standard broad questions which could be supplemented by non-standard probes to facilitate further exploration of the participants’ views and interests. Smith (1995) suggests that questions should be neutral (rather than value-based), replete of any jargon and open (rather than closed). “Why?” questions and particularly abstract questions should be avoided (Wilkinson *et al.*, 2004).

Questions explored the participants’ views in the following areas: what meaning they attribute to having depression; what they make of their attempts at coping and help-seeking; what the impetus was behind their decision to seek therapy; what they anticipate taking place in therapy. A full copy of the interview schedule is presented in *Appendix 4*.

The order that questions were presented in followed the most logical sequence, which was the direction in which the story most naturally goes. Questions were oriented to start with the least analytical and most concrete questions, to ease the participant into the interview, and allow time for a rapport to be established, leaving more abstract and speculative questions until later in the interviews. The order of the questions were varied according to the “flow” of an individual interview to more easily facilitate the participants’ expressions.

Data collection

Data were obtained from transcriptions of the digitally audio-recorded semi-structured interviews. The duration of the interviews was between 60 minutes and 110 minutes (mean = 88 minutes). Audio-recorded interviews were transcribed verbatim with reference to guidance in the literature (Bailey, 2008; Jencks 2011), according to basic orthographic conventions. Transcriptions omitted visual cues such as body language, and included some paralinguistic information such as the use of intonation for emphasis, laughter and the use of non-words. Typed transcripts were read whilst re-listening to audio-recordings of the interviews to improve accuracy. This formed the data corpus which were analysed using the procedure described below. While participants were given an opportunity to amend or add to their transcripts, non-chose to do so, potentially reflecting a reluctance to think further about the issues regarding their depression raised in the research (Moses *et al.*, 2007).

Data Analysis

Thematic Analysis (TA) is an approach to qualitative analysis which involves ‘identifying, analysing, and reporting patterns within data’ (Braun & Clark, 2006, p.6). At the heart of TA, is the iterative process of drawing and redrawing thematic maps. They represent the culminated understanding of the data set through its interconnecting themes and sub-themes. Braun and Clark (2006) proposed the following six-phase guidelines which describe the manner in which data from the transcribed semi-structured interviews can be organised into themed meanings.

In phase one of the analysis I familiarised myself with the data, by repeatedly listening to the audio-recording of the interview and reading the verbatim transcripts. Following the guidance, I highlighted items of interest and made notes as I tried to understand how the participant was making sense of their expectations for therapy. Alongside this, notes relating to my assumptions were captured for reflexive purposes.

With the second phase, this observational stance progressed to a more systematic response to the data for the purpose of code creation. Data blocks were labelled, using the comments feature in *Microsoft Word*, so that they could be categorised in relation to the research question. This categorisation served to capture meaning in the data at the descriptive and semantic levels. The participant's voice and frame of reference was prioritised (Braun & Clarke, 2013), however, conceptual meanings were captured as is consistent with a contextualist approach (Braun & Clark, 2006). Subsequent to a code being applied, a new section of the data was examined to decide whether a previous code was applicable or an additional code was required. Occasionally data segments produced more than one code, and revisiting and modifying older codes formed a part of this process. Codes were exported to *Microsoft Excel* for the broader task of analysis, and to verify the accuracy of the code applied.

In the third phase, a progression from generating individual codes to the formation of broader themes involved searching the data set for patterns. Codes that shared a common feature in relation to the research question were clustered. Those codes that were less relevant to the research question were excluded. Braun and Clark (2013) state that although themes will be distinct from each other at this time the researcher should be starting to consider how together the themes bring meaning in trying to answer the research question. Overarching, or super-ordinate themes, began to be identified which helped to establish an approach to this

Due to the specificity being high in the early stages of analysis, the number of codes and themes yielded were too numerous to be able to coherently report the data. Boards and movable labels was used as a pragmatic way of reducing their number. During this process many of the codes that had been brought together as "themes" were collapsed into single codes. Data items were therefore merged, moved or put aside. A separate board was used to organise the newly developed codes into themes that were partly based on the earlier phase of the analysis, and modified according to adjustments made in the development of the codes. This phase culminated in the development of an initial thematic map.

The fourth phase involved checking the robustness of the analysis. This was performed by looking at the coded extracts against their respective codes and themes for fit, in terms of how accurately they captured participants' meanings. The adaptive nature of the analysis meant that the steps involved in phases two to four were revisited recursively, and at times, somewhat in parallel. Themes that were less coherent and had less relevance to the

emerging central theme were either re-drawn or eliminated in a way that was judged to benefit the *message* that the report would carry. The clarification of the superordinate themes aided the selection and presentation of the data, and this was supported by the development of thematic maps, which were progressively modified. The final version can be seen in *Appendix 6*.

Subsequently in the fifth phase, themes were named and defined. *Appendix 7* presents the outcome of these phases, illustrating how the overarching themes, principle themes, sub-themes and codes were organised. The naming of a theme was approached in two ways, firstly by attributing a label reflecting its content and also by writing a phrase that captured the essence of the participants' voice. It was hoped that these adequately represented the narrative of each theme, which was captured in a few sentences to provide a coherent description.

In the sixth phase, the final stage of the analysis, the report was produced (see *Results* section below). This involved using a selection of exemplifying extracts to further construct the narrative of each theme. This was achieved by describing and interpreting the data, and by drawing on the relevant literature and theory. A principle aim of this process was to include a broad a range of extracts within a theme to try capture the participants' individual perspectives. As per Braun and Clark's (2012) suggestion, the analysis attempts to weave between descriptive statements about specific extracts and summative statements within themes that are more conceptual in nature. The analysis also sought to be holistic; connections between the themes and the research question and between the themes themselves were identified, and the resulting conclusions reported.

Piloting

Piloting is a conventional method of improving the quality and rigour of research (Marshall & Rossman, 2011), and it takes into account that that the process of constructing questions in qualitative research is iterative (Smith, 1995). Consistent with recommendations (Braun & Clark, 2013), the research was reviewed by way of supervision following a couple of initial interviews. Although these were generally regarded as positive research experiences there were a number of areas identified for improvement. One such area was related to a strength of these interviews, that they facilitated both participants' openness to express themselves. The main observations were that: the interviews produced too much data, the first being well over the projected time of around 80 minutes; the interviews produced more data that was less relevant to the research question; the interviews presented a risk

of becoming what participants wanted from therapy (Grafanaki, 2002). These concerns had implications for both the practicality of carrying out the research (Francis *et al.*, 2010) and the need to produce a data corpus that provided the basis for an analysis addressing the topic of interest (Braun & Clark, 2012), i.e. pre-therapy expectations. They also had implications for my role as a researcher, and these are explored in the *Reflexivity* section below. When the content of these initial transcriptions were read they contained more information on the topic of their depression than was anticipated. In solution to this problem, this section of the interview was reduced to fewer key questions on the topic. Alongside this, it was decided that follow-up or probing questions would be used more judiciously in relation to this set of questions.

Considerations for Methodological Rigour

In addition to piloting the interview schedule, a number of other measures that contribute to improved quality and rigour in qualitative research were considered. Braun and Clarke's (2006) gold-standard criteria for thematic analysis (see p.36) were used as a reference guide at each stage of the research.

Once the audio-recorded interview was transcribed, participants who accepted the offer to receive a copy of their interview transcript were invited to amend their comments or provide additional clarifying information. Furthermore, upon completion of the thesis a summary report will be provided to participants who may provide feedback about the conclusions made. This participant feedback will be taken into account in any article subsequently submitted for publication.

Another degree of triangulation (Yardley, 2008) was sought at various points throughout the analysis, with the research supervisors providing an additional perspective about the coding, the categorisation of these into themes and the subsequent interpretation reported in the results section.

Finally, I have adopted a reflective approach which has included keeping a reflective journal and acknowledging the assumptions I hold, to try to understand the bias I introduce in this research (Eatough & Smith, 2008). These are reported below.

Reflexivity

Qualitative research invariably involves a task of hermeneutics on some level (Ashworth, 2015), and the contextualist position adopted, has involved trying to balance the need to be empathic to the participants' attempts to make sense of what they will experience in

therapy, with the hermeneutics of suspicion, to try to make sense of these meanings using the participants' broader contexts as a framework of understanding (Willig, 2012). This inevitably involves some level of interpretation of the participants' meanings on the part of the researcher (Ashworth, 2015). To bring transparency and awareness to this process of interpretative phenomenology, and specifically to understand how I have influenced the interpretational aspects of this study, it is important that I try to examine my own assumptions and preconceptions (Eatough & Smith, 2008).

Professional background

The interest in expectations is highly relevant to my clinical practice. In my experience the decision to go for therapy is a significant step that is experienced as an anxiety-provoking experience for many clients. Consequently I assume that there are significant expectations associated with this decision. Curiously, however, when I ask clients if they have any expectations about the therapy when I first meet them, typically I am not inundated with their thoughts about what they imagine will follow. I am much more likely to hear about the heartfelt hopes and fears that they had in anticipation of the therapy after a significant number of sessions have passed, typically once a good working alliance has formed (see Holmes, 2001). Even then, I am curious whether the comments made actually represent the tip of a very large iceberg that includes a vast array of experiences, potentially ranging from a sense of themselves as someone who is well enough, to someone who has come for professional help feeling deeply in conflict with themselves. Yet this information remains largely unknown to me (Jinks, 1999). I expect that this is paralleled in the client's own experience: not knowing how I will be as an individual therapist, and what I might offer them by way of help. My perception is that as therapists we sit with the uncertainty of the situation in expectation that a shared understanding will develop, and that, done well, this will be holding for the client (Howard, 2010).

My eagerness to learn about clients' expectations is likely to reflect some anxiety and tension between this idea of managing uncertainty and the reality of my situational context where the time available for exploration, which might yield understandings around expectations, is very limited. Clients allocated through the service I work in will have had a considerable wait and I assume would be anxious to receive help to address their concerns. Sessions are time limited and there are considerable pressures around contracting, assessing and formulating, and in the case of CBT interventions, implementing the protocol. This has prompted thoughts, for example, what would the client reveal to the therapist

were they given ample opportunity? Are there things that might be difficult to reveal to the therapist that a study would be better placed to understand?

Further motivation for the research stems from a number of experiences of helping individuals whose implicit expectations had a significant effect on the therapy, illustrating how ruptures negatively affect outcome expectations (Westra *et al.*, 2011). Since the awareness that emerges from ruptures can also be a part of making progress in therapy (McLeod, 2013), such experiences have given me cause to consider, what are the questions that I might have asked that would have been helpful in identifying, understanding and managing these difficulties? Perhaps there were things in the clients' presentation and story that I might have paid more attention to?

Personal background

A vested interest in this research is derived from my personal experiences of low mood. An element of my own experience is that when I had difficulties as a young person I had not made the decision to seek help. At the time there was insufficient awareness of mental health issues for me to interpret my experience accordingly. I also have had conversations with friends and relatives, in non-professional contexts, about their help-seeking for depression which have affected my views on the topic. The issues raised have included: a reluctance to seek help; beliefs that their expectations would not be understood or taken seriously; difficulties being able to communicate their precise needs; generally not knowing what therapy is about. The latter was encapsulated by a recent experience, after the process of undertaking the research had started to influence my dialogue with clients around their expectations for therapy, one of them remarked, "it's like it's [therapy] some big secret!". These experiences have increased my belief in the importance of investing in clients' expectations as a way of attending to their help-seeking needs.

In thinking about how I as an individual will potentially influence this research as I interpret participants' meanings, it is useful to consider how my status overlaps with or is different from the participants'. As a white male of similar age to many participants (mean age 40), I may have an 'insider' status, and some of these participants will have grown up with similar outlook about mental health and professional help. Since the youngest participant (20 years old) reported having a healthy dialogue about his depression with his peers, perceived issues around stigma may be generational (Rickwood *et al.*, 2005). The issue of insider/outside status is often obfuscated by 'similar but not quite the same' nature of experiences (Deutsch, 1981). Participants who belong to non-privileged minorities may

have values and norms that fall outside the dominant social order, and may therefore have contrasting experiences relating to their societal membership. This might include their experiences not being acknowledged or validated, with the impact of having a marginalised status in society (Ivey *et al.*, 2013). One of my principle areas of learning from therapy was how disempowered I felt when I found it going in an unwanted direction, and the difficulty of trying to challenge that. As someone who knew what therapy is, I imagine that this could be experienced more acutely by people who have less familiarity with it and I wonder how it might be experienced by people from more disadvantaged backgrounds. This experience also highlights the impact of what can happen when what a therapist wants is not what the client wants. This further strengthens my conviction that understanding client expectations has a legitimate role both in supporting the therapeutic alliance (Constantino *et al.*, 2005; Gibbons *et al.*, 2003) and in paying due care to a client's agency (Cooper, 2009).

Reflective research diary

An important intervention which encourages reflexivity and allows potentially influencing thoughts and perceptions to be captured, thereby understanding my researcher bias, is the research diary (Parker, 2005). A selection of observations will be described to highlight the challenges I faced in trying to manage my subjective responses and deal with scenarios in the research interviews:

- Across a number of interviews, my notes reflect the extent to which my initial (unspoken) response derived from a practitioner perspective. As McLeod (2015) states, difficulties containing these separate roles can have a negative impact on the interview. I noticed that I was having to invest considerable energy in looking out for and inhibiting these responses so that I could attend to what participants were trying to tell me in relation to their expectations.
- Reflecting on why I was spending a lot of time talking with the first participants about depression, I came to understand that I was carrying an assumption that these connections would be found in the depth of their experiences, and consequently I was having difficulty knowing when to stop and move on. West (2002, p.264) refers to the danger 'hit and run' research, where therapists use their skills set to gain in-depth knowledge and leave participants without adequate support. This ethical issue was dealt by keeping more rigidly to the structured element of the part of the interview in which we discussed their experiences of depression. I assumed that participants would

discuss their depression as they spoke about help-seeking and expectations for therapy, if they thought the connections were relevant. Hopefully this enabled participants to exert more agency in telling their story of their expectations for therapy.

- In parallel to therapy, some clients' expectations of the interview were different to my own. This was most striking in the interview with Simon who wanted to talk about the failure of health services / society to meet the needs of people with depression, which lead him to talk about third parties, with a loss of subjective perspective I was interested in. On reflection, I noted that I could have discussed whether I had still had his consent to continue with the interview on the basis originally agreed to (Grafanaki, 1996). I captured the feelings of anxiety and frustration that I had felt in the interview, which potentially offered me an insight into his experience of the inflexible nature of a society seemingly unwilling to reach out to those in distress. Such feelings also related in part to uncertainties that I recorded following other interviews. Reflecting my doubts and inexperience, when I listened to the interviews at home I realised the value in the unique perspective I had captured.

Results

A thematic analysis of the data, on the subject of expectations for therapy, captures a central concern that pervaded many of the participants' answers: Can I be helped? *The prospect for change in me and my problem*. The themes I generated were assembled into the following three overarching themes (see Thematic Map in *Figure 1* below).

The first, *Therapy – a faint hope for me*, describes how participants sought to make sense of whether therapy could really offer them any hope of getting help with respect to their depression. This overarching theme was connected to two principle themes: *could therapy work: hope versus hopelessness* and *because I'm flawed*.

The overarching theme, *Being helped to heal myself*, captures the often previously absent features participants described as being necessary for them to be able to work towards improving their wellbeing, and was comprised of three principle themes: *being open and accepted, I want to better myself but I can't do it alone, finding a good helping relationship*.

The third overarching theme, *How to deal with my Depression*, explores how participants sought to understand how they would resolve or manage their depression, and was linked to two other principal themes: *understanding how to get back on track* and *whether to control or eliminate depression*.

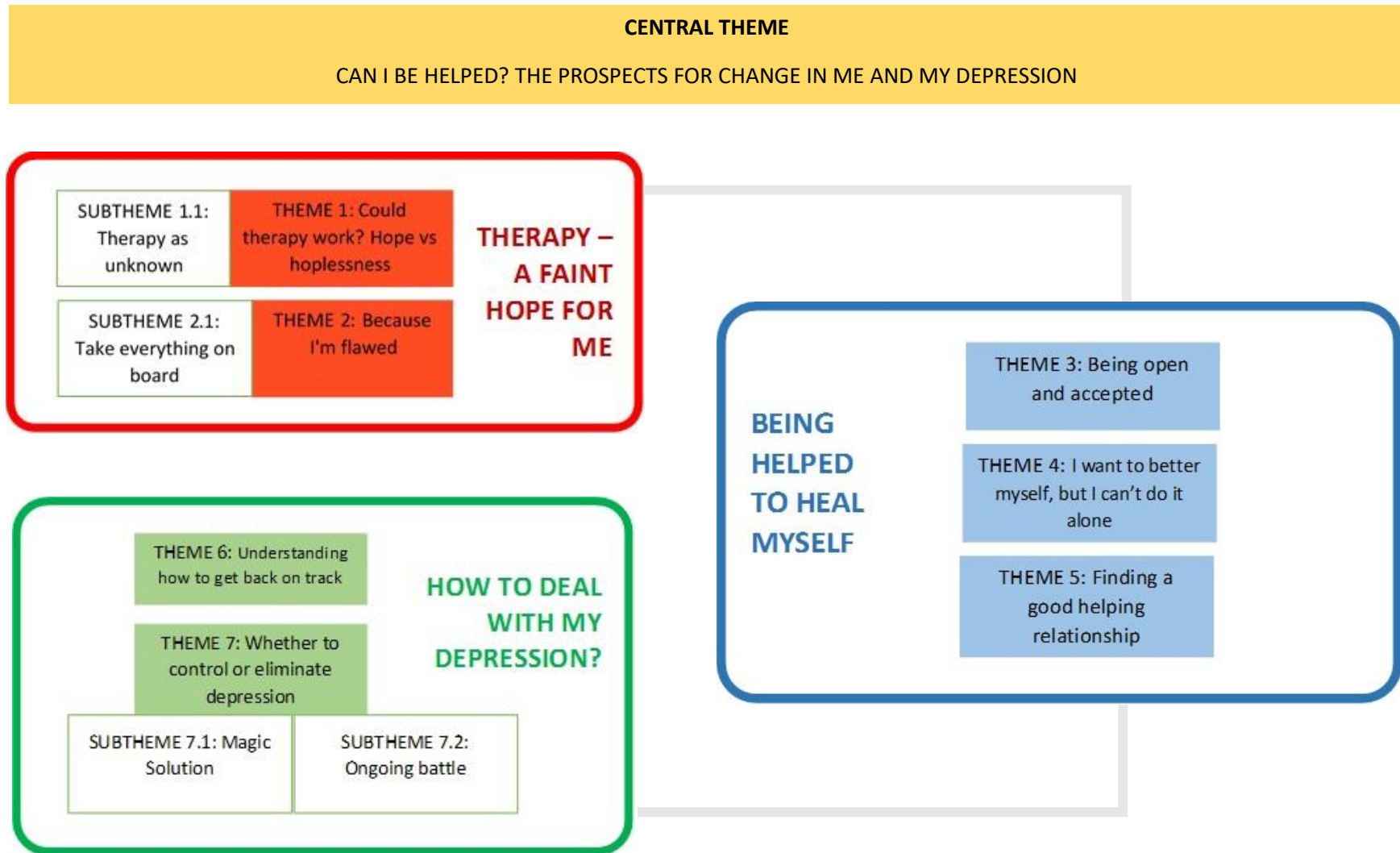
Each of the themes and subthemes will now be explored, with accompanying extracts. The extracts presented will have been edited for ease of reading, and this may include removing hesitation, and incomprehensible or irrelevant speech.

The experience of participating

Participants were invited to comment on their motivation for taking part in the research. Almost all of them expressed a desire to contribute to a body of work that might help similar others. For Simon, this was apparent throughout the narrative of his account, highlighting the challenges that people with depression may face in obtaining the help they really need.

Now I know someone else, who doesn't have that support network around them, and I think yeah when we come back to this sort of bit about failures of support, people are falling through the gaps all over the place

Figure 1: Thematic Map



The emotions reported by participants after having talked about their expectations were varied. Many said that they felt positive for having talked about the prospect of going for therapy. For a few they felt that their exploration of the issues relevant to the topic marked a promising sign that they would cope with or benefit from therapy itself.

*I think it is like this, it's been a good thing, just exploring it with you,
yeah, I think it will be good to do it [therapy] (Lisa)*

In contrast, Michael, whose therapy was starting imminently, was noticeably anxious at the end of the interview:

*I'm still OK, um, probably a bit more anxious than I was, but it's to be
expected. Whenever I talk about things it always sort of brings on a bit
more anxiety, but uh, yeah I'm fine.*

While most other participants did not express anxiety at the end of the interviews, the sentiment of uncertainty about what therapy would entail was expressed in most of the accounts captured (see also Midgley *et al.*, 2016). Although this is explored further in the analysis reported below (see subtheme 1.1), it reflects a wider concern that clients who are facing therapy or counselling for the first time approach it from a relatively uninformed position (Elliot *et al.*, 2015).

Finally, many of the participants reflected that they did not speak to others about their depression or their needs for support, which is consistent with the finding that help-seeking is reduced amongst those with depression (Roness *et al.*, 2005).

OVERARCHING THEME 1: THERAPY – A FAINT HOPE FOR ME

This overarching theme reflects the difficulties that participants have had in trying to understand whether they as individuals they could meaningfully benefit from the help that may be available. All participants reported a mixture of expectations about the potential for therapy to alleviate their condition, seeing both the positive and negative possibilities. Also affecting expectations, almost all of the participants brought a sense of themselves as individuals as being part of the problem.

*Uh, I'm all for it [therapy] but at this point I've not being able to get
through this, it just feels like a dead end when it comes to these issues.
So if that's starts to break through that brick wall (Allan)*

Put those things together and it is very difficult to get out. You create this trap for yourself, this box (Mark)

THEME 1: Could therapy work? Hope versus hopelessness

This theme captures how participants expressed their feelings of hope and hopelessness for therapy, and how these affected their expectations about whether they would fulfil their goals. Making reference to their experience of trying to overcome their depression, participants described a pattern of easily becoming trapped in their low mood (Emslie *et al.*, 2007; Midgley *et al.*, 2016; Rhodes & Smith, 2010), and hopelessness about being able to learn and use ways of coping (Allen, 2007; Taylor and Loewenthal, 2001). Participants also reported more optimistic expectations for therapy, such as how therapy presented them with opportunities to benefit, and ways of seeing themselves being successful in therapy. That participants enter therapy not knowing what it involves hinders what they can anticipate in terms of the process and outcomes of therapy (Codony *et al.*, 2009; Elliot *et al.*, 2015).

Hopelessness

Most participants expressed hopelessness around their recovery prospects. Allan said he was, “getting a little bit tired now of going round and round in my mind with this”. Attempts to mentally resolve his depression had been ongoing and ultimately unsuccessful, and this had left him feeling exasperated. From their depressive experience, participants found it difficult to envisage being outside of it. The narrative in this account was one of depression being unrelenting and endless. Participants often described depression as a trap that they fall into and can’t get out of:

It doesn’t take a lot then to tip me back if I get myself better, it just takes a very little thing now and then I’m back in the loop, when I’m really down and everything goes tits up, then it’s really hard to get out of once you’re in like the circle of things, which is....annoying” (Emma).

This echoed others’ accounts about how effortful it was to improve their wellbeing, and by contrast, how effortlessly their mood deteriorated, causing feelings of frustration and anger. Lynda reported that this pattern had worsened: “the more I have the harder it is to get out”, suggesting that her feelings of hopelessness and depression could be interlinked

(Abela *et al.*, 2012; Beck *et al.*, 1993). Longer episodes of depression are associated with less positive expectancies for depression (Moses *et al.*, 2007).

Participants often related their hopeless feelings for therapy to their experience of being unable to cope with their depression: “I’m thinking how will I control it when I’m feeling down. Because I can’t” (Emma). Some participants reported their experiences of not being able to implement coping strategies that they had knowledge of. Emma, a health professional spoke about how she supported others with depression, but found herself being unable to act on her own advice: “bring it into my personal life and it’s completely different kettle of fish. I’m completely contradicting myself because I can’t do it myself”. She highlights a mismatch between her professional opinion of how to manage with depression and what her subjective experience indicated.

James explained how unsuccessful attempts to improve his mood caused him to question what could help, fuelling his feelings of hopelessness: “what do I do then that will uh make me feel better if you try a number of things and it’s just not working, you kind of lose a bit of hope.” The co-occurrence of helplessness alongside hopelessness, as evidenced in these accounts, is well documented in depression (Alcalá *et al.*, 2012; Henkel *et al.*, 2002).

Participants expressed hopeless feelings about whether therapy would help them. Allan said, “the best hope would be for some sort of basic paradigm shift in my perception of myself. That would be amazing but I don’t expect that to happen”. Here, the prospect of therapy delivering his hopes was not conceivable, leaving a sense of unfulfilled expectations. Some participants shared more pessimistic expectations around their recovery, such as Michael, who stated, “I’ve got no illusions that I will be free of this, I’d like to be, but um, you’re only as free as you can make yourself be I suppose.” His account implies that he would need to adjust to living with depression, making of it what he could. These accounts support literature indicating that clients with hopelessness had reduced expectations of improvement (Goldfarb, 2002; Nock & Kazdin, 2001). Unsurprisingly, these are associated with higher pre-therapy rates of attrition (Issakidis & Andrews, 2004).

Hopeful Self

Participants described the ways in which they saw themselves being successful in therapy, supporting existing literature (Tsai *et al.*, 2014). Participants made predictions of being more elevated in mood: “I’m hopeful that I’ll come out if it feeling more positive” (Allan).

They wanted and hoped for positive outcomes in therapy: “I’d like to think it’s achievable. I want it to be achievable” (Adam). Participants occasionally expressed positive feelings in anticipation of therapy: “Well it [therapy] was something I was quite looking forward to” (Gareth).

Michael described how his experience of successfully training his colleagues at work gave him faith that he could change:

You see people come in and uh they’re pretty useless some of ‘em, and you can turn ‘em round. You think they ain’t going to make it and they make it, and become stars in what they do.

This narrative reveals a belief that those that appear like hopeless cases (with the comparison indicating that people with depression do), could be assisted to significantly better themselves, potentially becoming examples of exceptional achievement.

Participants made reference to qualities they possessed which could contribute to positive outcomes in a talking therapy: “I am very sociable I’m very good at talking, I’m very good at making conversation, I think it’s just getting me to that point” (Sarah). As with other accounts, this indicates an expectation of receiving assistance to feel confident or able to express her positive qualities.

Providing further support that clients may hold positive outcome expectations (Constantino *et al.*, 2011), a number of participants considered that therapy would deliver hope for their future:

I think it [therapy] will help me be a better person, it will help me give my children a better future or a better chance

Participants anticipated that a hopeful approach would have positive repercussions for the outcomes achieved in therapy: “usually I get results out of people by being more positive” (Michael).

Therapy as Opportunity

Participants anticipated that therapy would provide a bridge to new opportunities (Watsford *et al.*, 2013). Some reported that the act of arranging therapy had been significant in itself. Lynda said, “it has taken a lot off my shoulders.” This highlights a sense of relief, perhaps signifying that the act was unburdening. The possibility that she had made an appraisal that the responsibility was now shared appeared to be evident (Moses

et al., 2007): “I feel a lot better knowing that actually a health professional knows.” She continues, explaining that these positive feelings were attributed to an anticipation of receiving help and a belief that she will be able to effect the desired changes in her wellbeing:

*It hasn't changed anyone's view on me, it hasn't changed how I feel but
I know that I'm gonna be able to sort this out and that there is actually
something in place*

Michael expressed feelings of curiosity and excitement in anticipation of therapy: “I’m excited about going to see exactly what it’s all about and um what can be gained from it.” While, the potential benefits of therapy remain a question in this account, other participants expressed ideas about what they would gain.

Many participants cited the opportunity to talk about issues that were rarely disclosed to others: “I’m alone and don’t have the opportunity to talk about things like this” (Mark). As was common, his account highlighted a lack of social contact and intimacy. Other participants’ accounts indicated that few relationships afforded the chance to discuss mental health issues: “Well I’d feel quite grateful, I don’t talk about it very often, so if I did find someone I’d hopefully feel that that person would be in my select few” (Gareth). This supports existing evidence that clients value therapy as an arena to discuss difficult-to-talk-about concerns. In one study this was seen to relate to the ability to preserve some anonymity (Emslie *et al.*, 2007). John highlights a difference between a conversation with friends or family, and talking to mental health professionals: “being able to talk about it in a more clinical environment”. This expectation suggests that psychological therapies would provide a more understanding space for an individual to reflect on their problems. By contrast, conversational partners may be more likely to respond from a position of subjective opinion and be influenced by their own needs within the relationship (Williams & Healy, 2001), making it difficult for the person to have their mental health needs met.

Some participants juxtaposed talking therapies with medical approaches, and distinguished them in terms of effectiveness: “I know people have gone back to antidepressants. I don’t think that would solve the situation, that’s not a long term solution for me” (Allan). Other accounts suggest that people regard therapy as a more realistic opportunity to managing their mental health concerns in the long-term, compared with medicinal options (Bradley *et al.*, 2010; Jorm *et al.*, 2005).

Participants regarded therapy as an opportunity to learn to cope differently with their depression, and this is explored further in a number of themes:

I'll have an alternative place to go if I get if I ever get as low as I did.

Yeah anything really which can open up the possibilities of where I can go

(John)

In addition to opportunities to develop new ways of being within therapy, participants also anticipated opportunities beyond their initial intervention: “y’know it might open the door to another form of therapy or something.”

Waste of time

Participants spoke about how therapy may not live up to expectation or be problematic. Many participants expressed concerns that it would have a mildly unhelpful impact overall, by consuming their time without improving their wellbeing: “Is it going to provide any benefits or is it just going to take up my time” (James).

Further uncertainty about whether therapy could be effective was captured in concerns about how realistic their treatments were, including the number of session they had been given: “how they can guarantee that I need six sessions in order to feel better” (Adam). Gareth similarly expressed a view that the limited amount of time available for support would be insufficient to meet his needs: “it will be an hour a week and I really think it needs something that is going to be a bit more fulfilling than that.” These accounts highlight issues that are in common with views about the capacity of a “one size fits all” model for mental health services to meet the idiosyncratic needs of its clients (Romanis, 1987). They also reflect the question participants had sought to understand, of what they could reasonably expect in terms of outcomes. For example, James reported that the therapeutic outcome as it had been explained to him was inadequate:

If you like you can go for this thing we’d recommend, it will probably

help you change the way you think, and I just said, “oh okay, big deal”.

It highlights the potential importance of existing recommendations about understanding clients’ expectations for therapy and providing a credible rationale for treatment (Horvath, 1990; Tsai *et al.*, 2014).

Participants raised logistical concerns about attending therapy. For some, disruption to their routine reflected a potential ambivalence about attending therapy (see Halgin *et al.*,

1987). Other participants considered circumstances that would potentially affect their ability to attend therapy sessions:

In a few months I could be going on a placement, and that might mean that I am not in [place] anymore, so I hope it but doesn't disrupt it too much (Sarah)

Similarly, Simon posited how geographical mobility for employment purposes would have an impact. These accounts highlight issues relating to whether services were sufficiently flexible as to accommodate participants' other undertakings in their life.

Expectations of how dissatisfaction with therapy could be managed were reported. Simon outlined his limited tolerance for dissatisfaction in therapy:

I tend to try to give people like at least three attempts, and if they continue to not address that problem then I tend to go well it's not worth me wasting your time with this

Giving therapists several opportunities to correct their approach implies an importance of being fair in how that expectation is brought. Where participants' accounts made reference to therapists' time being wasted they stated that it would be more productively spent helping others, potentially reflecting doubts about whether they can be helped.

Participants' accounts highlighted the issue of communicating their discontent to therapists: "If I felt it wasn't working I don't know if I would be able to tell the person or not" (Adam). This further evidences difficulties clients have in providing constructive feedback to their therapists (Levitt *et al.*, 2006). This account highlights a concern about how this disclosure would cause harm to the therapist, and potentially reflect negatively on themselves. This concern was not universally expressed with Gareth saying:

I had pretty much have to say it's not working. Yeah I don't really wanna waste my time, certainly don't want to waste the time of the professional so I'd have to say "sorry" if it's not working.

SUBTHEME 1.1: Therapy as the Unknown

This subtheme captures how many participants had difficulty conceptualising whether therapy could benefit them because they possessed little knowledge of what it is or how it could help, as has been evidenced in other recent accounts (Midgley *et al.*, 2016;

Watsford *et al.*, 2013). Participants typically were able to answer questions about depression and help-seeking, while they frequently responded to questions about therapy with uncertainty: “it’s a hard one. I don’t know. That’s the question isn’t it.” (Michael). Similarly, Lynda was unsure about the content of her first session of therapy:

what’s going to happen, what are we going to talk about, um, that’s really what’s on my mind at the moment, not knowing what to expect, yeah. All I know is go to [location of therapy].

Participants expressed difficulties forming expectations for therapy. Adam stated he did not understand what to expect of his own role: “I don’t know what she will expect me to do. Or say.” Lynda did not know how long individual sessions would last: “[I] can’t even tell you how long it’s going to be.” Michael expressed concern about working with an unknown person: “I’m going to see somebody on Wednesday but I’ve never seen or spoken to them”.

As has been reported elsewhere (Maier & Straub, 2011), many participants reported that they had gone along with prompts by family members, resulting in GP referrals: “I went back to see the doctor and he recommended therapy” (Michael). Helpfully, participants reported having information about depression: “he emailed some information across for me to read, and then there was a questionnaire which I filled in and it came back with the depression” (Mark). Significantly, none of the participants reported receiving information about what therapy is.

Emma identified that a contributory factor was not being able to talk with others who had been for therapy: “I don’t know, because I’ve never known anyone that has sought therapy, I’ve got nothing to relate it to.” The absence of information and difficulty finding others who have experienced therapy to relate to are potentially barriers to participants forming realistic expectations (Richards *et al.*, 2003). These accounts portray therapy as hidden (Elliot *et al.*, 2015), causing participants to experience negative emotions in anticipation of going for therapy: “That’s why I’m very nervy, and very anxious about what’s gonna actually happen. Cos that bit hasn’t really been explained” (Adam). A poor understanding of therapy is known to negatively contribute to therapeutic expectations and engagement (Horvath, 1990; Roos & Werbart, 2013), potentially influencing the placebo effect (Benedetti *et al.*, 2003).

This theme describes the ways in which participants identified themselves as having potential flaws, with participants wanting any help that they receive to take account of these deeply distressing elements of their depressive condition. The narratives appear to indicate participants held an orthodox view of their disability. In this paradigm problems are seen to be located in the individual, who are regarded as unfortunates and necessarily dependent on others (Barnes & Mercer, 2004).

Deep Problem

Some participants described how they themselves had become a serious problem. The idea that some psychological issues could be so serious as to be rendered inaccessible to their conscious minds, or repressed, in order to keep them from harm (Howard, 2010), was expressed by some. Participants hoped to unravel their psychological and emotional memories into revealing the issues which underlie their present affliction:

*Therapy will jog my emotional memory into remembering some things
which are probably tucked away for a good reason (Allan)*

The perceived seriousness of the nature of these issues was reflected in a desire to purge them from their minds: “there is something very deep there which needs to come out” (John). Allan conceived of needing therapy to resolve a conflict between the known and unknown parts of the self, saying he would, “have it out with myself really.” These accounts echo those reported by Rhodes and Smith (2012) about themselves becoming the core features of their depression. It fits with the concept of having depression about depression, which tends to see depression as being caused by character flaws and consequently not being malleable to treatment (Fennell & Cambell, 1984).

Inadequacy and Damage Limitation

Consistent with other accounts (Goldfarb, 2002), participants were aware of and frustrated by the counterproductive nature of their responses to problems, observing that this caused their situation to spiral, and fuelled concerns about therapy. The following account evidences how inadequacy concerns can negatively affect self-efficacy, which is known to influence outcomes in depression (Brown *et al.*, 2000): “when I’m depressed it’s impossible. There is no goal, the goal is not possible.” (John). Many participants explained that they sought to curtail the injuries subjected to their self-esteem: “the bad will still be the pride” (Lynda). This risk-averse behaviour reduced participants’ capacity to accept positive feedback: “it’s very hard to listen to somebody to try and tell you everything’s going to be fine, you blocked out the positives so you don’t have to deal with

the negatives” (Mark). Typically they spoke of managing expectations to reduce the risk of feelings of disappointment and failure: “I’m afraid that if I put my hopes up to high that I might be disappointed” (James). Often participants reported managing their expectations for therapy: “I don’t get a joyful feeling, again it’s just in the middle, I’ll see what happens” (James). This narrative highlights how some depressed participants may have been adopting a cautious stance through harm avoidance (i.e. reacting with pessimism, worry or avoidance of uncertainty) resulting in difficulties generating positive expectations for therapy (Moses *et al.*, 2007).

Self-sabotage and masochistic tendencies

Often participants described ways in which they had acted against themselves, making their predicament worse. Sarah described how having an unhelpful perception of themselves was a barrier to overcoming depression: “I think it’s very easy to have the wrong view of yourself, you can be your own worst enemy”. Michael further explained how this self-awareness exacerbated his low-mood, because information about their weaknesses and failings were readily accessible and focused upon:

It’s coming from yourself and you know yourself better than anybody really, how you feel inside, and your own deep thoughts and dark places, and so forth, and it plays on those

Accounts were consistent with research indicating clients often seek to avoid thoughts relating to their low mood (Moses *et al.*, 2007): “they feel that if they analyse themselves too much they might find themselves wrong” (Simon). The self-loathing reported in these participants’ accounts are consistent with other accounts (Granek, 2006). Participants adopted this avoidant approach in thinking about what therapy could entail: “[I] try not to um analyse what they [the therapist] are going to do” (Michael). These narratives highlight the automaticity of their negative appraisals (Lawson & MacLeod, 1999), and how these affect their expectations for therapy (Rutherford *et al.*, 2010).

Simon, like a number of participants had difficulty identifying a rational understanding for their self-defeating behaviours: “you sort of go why is that and you don’t get any answers”. Participants expressed frustration at not responding more constructively: “it’s so hard when you’re a person like myself that knows the different side, knows the right way of life” (Emma). For Michael, this dissatisfaction shaped his expectation for a role in therapy addressing this issue, as well as positively influencing his motivation: “I don’t want to be like that. I wanna do something about it.”

SUBTHEME 2.1: Take it on board

This subtheme captures how many participants had developed the specific expectation they would need to be receptive to anything that the therapist provides in therapy, as a means of eradicating their own flawed way of managing their depression. It might also reflect low expectations for receiving help for their depression (Perry & Magnusson, 1988), and in this way using what they perceive as a limited option for addressing their difficulties.

Participants were fairly unanimous in saying that, “you take on board what they want to show you” (Lisa). Many spoke of the challenges they had faced in trying to be receptive to the help they got. Lisa pointed to a need to improve in this respect: “what I wouldn’t have been able to do before, but take on board what they are exploring with me.” Indeed, participants saw their receptiveness to help as essential to the usefulness of therapy: “I need to hear them and I am ready to” (John). This is consistent with existing literature supports the importance of a person’s readiness, or stage of change, to the utilisation of therapy (Norcross *et al.*, 2011).

Participants explained what being receptive to help would involve, for example, Michael emphasised the need to reject his own cognitions: “as opposed to um trying to adapt it to your own way of thinking, cos um, quite clearly my own way of thinking isn’t a 100 percent”. Similarly Simon reported that he had been unable to untangle his experience of depression independently hence the need for help: “ultimately, these are things which I’ve not been able to solve myself so therefore I cannot actually come up with an explanation of what’s happened”. These accounts support roles for therapy in helping clients with developing new skills in problem-solving (Allen, 2007) and in the task of sense- making (Lewis, 2015). They are also illustrative of a narrative about taking responsibility, similar to that reported by Johnson and colleagues (2012).

To ensure that they took sufficient advantage of therapy participants expressed a clear expectation that they would try to be impartial: “I’m going in for it as an open minded as possible” (Simon).

OVERARCHING THEME 2: BEING HELPED TO HEAL MYSELF

This overarching theme reflects participants' attempts to understand how they might heal, through what they and the therapist bring, respectively. All participants reported some awareness or fear of stigma, consequently participants typically held expectations of being open and accepted in therapy with a degree of reverence. Many participants alluded to an idea of an improvement in their condition needing to come from within, while also describing a role of the therapist in facilitating this in some way. Expectations about the qualities relevant to a good helping relationship were reported as being crucial to the issue of being helped.

When you take that I have a problem I need to fix it, you actually sort of go no actually no this is not my fault um and I need to get help and different things (Simon)

That would be good if you come away with a feeling that okay I'm not perfect, nothing is perfect, I'm still doing things wrong but I can accept that I'm doing things wrong and before you get to the over the edge you can step in there and maybe put them right (Lisa)

THEME 3: Being open and accepted

This theme captures how participants sought to explore and understand their difficulties whilst facing the challenge of overcoming the stigma around their condition. Depression is widely understood as a problem of social isolation and disconnection (Granek, 2006). Participants hoped to receive empathy and that their problems would be normalised.

Openness

Participants reported an expectation of openness between the therapist and themselves, with this being beneficial. The accounts here share some similarity with the *Talking Cure* (Midgley *et al.*, 2016) and *Just Talking* (Watsford *et al.*, 2013) themes reported previously. Participants anticipated that being in therapy would require them to describe their concerns: "it's obviously about introducing yourself which I think I can do that, I think I can put an honest account" (Allan).

Lisa had an expectation of being willing to discuss everything, including those less pleasing aspects of her experience: "I think they will expect me to say it all, warts and all." She also related to a need to reveal everything, expelling all of her significant experiences to the therapist: "at least I would have spat it all out. Got every single thing out." She continues:

“I don’t think I’ve told anybody every single thing.” The confessional nature of this need to re-tell her whole story was reflected in a number of other participants’ accounts, and as Lewis (2012) explains, this can be explained both by their self-loathing and by their inflated sense of responsibility.

The potential benefits of being open were explained by participants, some of whom drew upon existing experiences: “I managed to get that bit out to her, that was a step to feeling better” (Lisa). This account indicates that as challenging as the revelation had been, overall it resulted in some improvement in her wellbeing. Emma reported that her experience of communicating with her family helped her to feel comfortable in talking to others: “I guess I’ve learned to talk about it more through my family which has given me confidence to then talk a little bit with other people that aren’t family.” This suggests that the experience of being open is self-reinforcing.

The importance of being open and truthful to the process of therapy was explored in others’ accounts. Emma anticipated that being able to share personal concerns was important to the effectiveness of therapy. James explained that openness would enable him to receive the most appropriate help from the therapist:

It’s the same when you go and see a doctor about anything you want to be honest about what’s happening and then they can get the full picture and say, “ah right, this is what you definitely need”

Accordingly, explaining all of the problems therefore results in a client’s needs being more likely to be met through the correct treatment.

Participants expected themselves to be emotionally open in therapy, as is illustrated by Sarah’s account:

I get the chance to open up to everything, I’ll get the chance to – I know it sounds really stupid – be emotional. Something that I am not, something I stop myself from and something I protect myself from.

This narrative suggests that she has refrained from experiencing her emotions as they pose some kind of threat. Pollock (2007) contends that outside of therapy, emotional distress often remains undisclosed as the support and social-esteem from others is seen to be conditional on this. Emma’s expectations of allowing her emotions to emerge are that she would benefit by experiencing them, perhaps through catharsis, and also by being able to understand them through dialogue and reflection:

A good cry is, I say it to everyone, it's really good to talk about all the bad, it's really good to feel shitty and upset and talk about it and think and react to it.

Significantly, both participants anticipated feeling safe enough in therapy to be emotionally available. These expectations of being able to express themselves emotionally were only reported by female participants, possibly reflecting differences in traditional gender norms (Strazdins & Broom, 2004).

Some participants who approached the need to be open in therapy with trepidation. Adam reported difficulties in understanding how to articulate his concerns: "sometimes you don't know what to say or how to get something out". This is consistent with accounts in the wider literature that people with depression find it difficult to find the vocabulary to describe their inner experience (Emslie *et al.*, 2007), in a way that might be comprehended by others. It could also be connected to a concern, as expressed by Mark, that what they say could be perceived to be unacceptable: "I think I would feel some of the things I think is wrong." Some participants' accounts indicated that their reluctance to communicate was connected to way they make attributions of responsibility for managing their depression (Barney *et al.*, 2009; Lewis, 2012).

Participants described expectations about their therapist helping them to make disclosures. John posited that therapists would be able to encourage disclosures by recognising when he is withholding information: "They can coax things out of you, cos you see one person who gets to know if you're keeping something back."

The expectation that their therapist would also be open was reported. Allan said, "I'm quite open to talk about myself, but uh, I'm looking for someone to be honest with me really". Allan indicates this would involve more realistic feedback: "those around you that obviously care about you, they are going to support you whatever you do". These narratives illustrate how participants value congruence, the principle that openness is an essential ingredient for change to occur, this having some overlap with the way that empathy is perceived in the relationship (Nienhuis *et al.*, 2016).

Threat of Mental Illness

Participants reported that needing therapy signified that there was something to be concerned about. Simon distinguished between short-lived illnesses that require a doctor's help with the severity of problem that must exist if it necessitates psychological support:

So it's, "oh your ill, but I'm sure it's temporary" or "I'm sure it's nothing", whereas going to the psychologist I think a lot of people go "oo you're going to the psychologist, there's a bigger problem there"

Simon's experience was that others have a tolerance limit about the degree of illness that is acceptable, and is comparable with the feminist concept of a rejected body (Wendell, 1996). Moreover, the need for specialist support may be viewed as inferring weakness or poor coping (Williams & Healy, 2001). Simply put, longer, more severe difficulties are more likely to be stigmatized (Jones *et al.*, 1984).

Some participants' accounts suggested that others fears that mental illness was a threat were internalised, as reported by Barney and colleagues (2009). Michael, expressing uncertainty about the limits of his own behaviour with depression, said: "y'know, I don't know what I am not capable of, y'know." He qualifies this, indicating that his inner mental world could become more than that: "You could turn". These accounts highlight a feared loss of control, as is common to many mental health concerns (Griffiths *et al.*, 2006). These accounts typically referred to an issue of repulsion, the sense of others not wanting to be associated with them if they discovered their condition (Barney *et al.*, 2009).

Some participants related to their depression as a potential madness. As reported previously (Orchowski *et al.*, 2006; Tambling *et al.*, 2014), media representations accounted for the narrative that mental illness equates to madness as presented by James:

Sometimes when you think about mental illness you can think about like crazy people, y'know recreate the picture like in the films

Improved communication about the treatment of depression would help to dispel clients' anxieties about having madness, and of presenting a threat to others (Barney *et al.*, 2009). The provision of pre-therapy information could confer benefits such as having more accurate expectations (Constantino *et al.*, 2011; Watsford *et al.*, 2013).

Empathy

The importance of being understood in therapy was expressed by most participants: "just having empathy for whatever your situation is" (Michael). This account highlights the possibility that each person's concerns and their context might be different, but that empathy should be offered regardless of what it is. Lynda considered that in order to

receive empathy, this would require a mutual effort from her and the therapist: “so I’m trying to get them to understand what I’m going through, they are trying to understand what I’m going through as well”. This illustrates how this may be understood and constructed in connection with others (Granek, 2006; Tice, 1992).

Experiences of having difficulty attaining empathy from others were commonly recounted. James, for example, cited difficulties with his parents: “I have talked about my parents as well, I don’t blame them, it’s just hard for them to understand”. He empathised with his parents’ task, and shared the responsibility for this outcome: “it’s hard to explain as well, there are no bad feelings there.”

Participants explained how they valued others’ understanding of them as individuals. Adam appreciated his GP’s ability to recognise his unspoken needs: “Cos I saw her about one thing and she goes there’s summat else isn’t there, and then another problem spilled out.” This account evidences how empathic cues can facilitate disclosure (Rogers, 2012). Michael identified the benefit of others accurately investing in his world-view: “he seemed to know exactly what I was like as well, and I felt a lot better, just by speaking to her.” This account highlights the positive emotional impact of receiving empathy, and this was also reported by others:

Maybe they cannot take away the feelings but they can be there so I find comfort in knowing that, y’know someone is with me, if you see what I mean (James)

Rather than being perceived as some antidote to depression, others’ empathy enabled him to feel as though others shared in and understood his experiences, which brought a sense of being secure.

Normalising Benefits

Participants anticipated the benefit of having their concerns normalised in therapy. A number of participants considered how society created idealised depictions of coping, a narrative which does not take into account the reality of the difficulties they faced:

Most people have this view of what an adult there should be as this sort of perfect being and they don’t necessarily think of people being floored, uncertain um and sort of muddling through each day just to try and survive (Simon)

It posits a fallacy of perfection in society, creating the expectation that it would be difficult for participants' to have their stories of struggling to manage their condition heard, understood and accepted (Reeve, 2000). This is further illustrated by Emma's account of regarding those she had herself referred for therapy as being inadequate: "The people who I refer are often what I see or judge as failures or I and others see as having faults." Since disclosures were anticipated to become an issue of self-worth, participants sought to limit their exposure to their failures by withholding information from the therapist: "people aren't going to tell the truth" (Mark). Participants spoke about the psychological discomfort that disclosing would cause, perhaps reflecting the uncertainty with which they would face such conversations (Midgley *et al.*, 2106), and concerns about how their disclosures will be received (McNair *et al.*, 2002).

Simon nevertheless emphasised the need to be able to communicate experiences that are not aligned to the mainstream narrative in society of coping, with therapy being expected to offer an arena to do this: "sort of sit down and go no actually we are [raised intonation], y'know we're not perfect, we do misunderstand things, y'know things go wrong." In this alternative narrative of acceptance, participants anticipated being able to develop a normalised perspective around their depression: "I'm just like you or I, and actually there's just this for little bit of me that is confused and needs unwinding and sorting." Mark expected therapists to normalise their problems to help them to manage the discomfort of disclosing: "having someone go to them and say this is quite a common problem, don't worry about this". Participants wanted to escape their experience of isolation and alienation: "then you realise actually you're not alone with this" (Lynda). This underlines the importance of understanding and acceptance in normalising their disclosures (Clement *et al.*, 2015). As these accounts indicate, this facilitates narratives of coping instead of narratives around not coping (Scattolon, 2003).

Participants valued comparative explanations that normalised their need for help with depression:

When you break a leg you need someone's help. I've broken my brain I suppose I don't know, it's my mind, I need help with it (Michael)

In this example, participants sought to equate depression with physical conditions, evidencing the way that they are inherently viewed as more acceptable. These comparisons helped to contextualise their need for help: broken parts of the body need to be repaired or fixed; diseases can re-emerge and require a more continuous provision of

care. These comparisons highlight how for some participants the medical model is useful in normalising their depression. Indeed, Barney and colleagues concluded that reframing depression as a health problem helped to reduce stigma (2009). Normalising depression in the context of therapy has the potential to confer significant benefits to their self-worth and identity (Clement *et al.*, 2015). These accounts indicated that others' normalising feedback is essential to overcoming narratives which explain help-seeking for mental health issues in terms of abnormality or inadequacy (Scattolon, 2003).

THEME 4: I want to better myself, but I can't do it alone

This theme captures how many participants anticipated and indeed sought autonomy around the management of their condition. Therapy was regarded as a means to this end, however given their previous difficulties with coping, therapists were also expected to provide facilitation through guidance and information-giving.

Self-healing

A number of participants expected that the purpose of therapy was to develop a capacity for self-healing. Michael stated that he would be supported to manage his depression by himself: "I think they'll be trying to get you to manage yourself and just helping you to do that". This supports a role for therapists helping participants develop an internal locus of control, which is known to have positive implications for the management and recovery from depression (Reynaert *et al.*, 1995). Lynda explained this in terms of needing to be responsible for her own wellbeing: "people can't be with you all of the time, you are your own first-aider as it were." This account indicates that the limited availability of support makes this the most viable expectation. It also links to a broader narrative in these accounts of being self-sufficient or independent. In the literature (Johnson *et al.*, 2012), this has been primarily linked with masculine identity, although a gender distinction was not apparent in these accounts.

Participants elaborated on how therapy would support them to manage their own depression. Michael anticipated that his coping would develop in tandem with an improved awareness around his experience of depression: "helping you understand what you're going through so that you can deal with it yourself." Michael extended this to an expectation of needing to develop responsibility for his wider welfare needs:

Self-management, it teaches you to look after yourself, to recognise your signs yourself, to know how to deal with them, and to understand when you need someone else to get involved

In addition to developing his own capability to manage depression, this would involve learning when help-seeking was appropriate. Support-seeking was necessarily a part of self-healing (Moses *et al.*, 2007). The accounts above potentially illustrate how ideas of self-management may also be an extension of self-regulated learning (see Williamson, 2015), that is, the way individuals take responsibility for developing, monitoring and evaluating their own learning.

Participants anticipated that competence and confidence would help them feel more robust around their own capacity to cope with depression: “I think in myself I will feel stronger. I’ll feel like I’m managing [slowly] things better. I feel like it will strengthen my confidence” (Emma). Emma envisaged that the therapist would be actively seeking to nurture their feelings of resilience, as part of helping clients to become self-healers: “to feed that strength then across to the other side so that they could manage themselves in the same way”. Participants indicated that improved self-belief was important to being more resilient:

It doesn’t matter how many times people say “of course you’re managing” because my confidence is low I can’t see it, I can’t embrace it, I can’t live it. I think once I get that strength I’ll be able to do that
(Mark)

This participant’s account evidenced how difficult it is for individuals to accept evidence of their successes if their beliefs do not support it (Beck *et al.*, 1997). Emma expected that having resilience and self-belief would help them to act how they wanted to be: “being able to do that instead of just think that”. James expected he would be able to deal with any relapse: “knowing if it somehow comes back how I can deal with it.”

Participants anticipated a number of benefits of being able to manage their depression by themselves. For Michael, this prospect was related to a broader sense of fulfilment: “self-control, because that means you’re living again, you’re back in control of your life”. A meaningful life is posited as one in which he would be able to live his life according to his own design. Michael envisaged this attribute, of having a sense of agency and control, being transferred to them from the therapist: “they’ve got the control and then passing their control over to the person”. Lisa stated that it would enable her to address her

difficulties, instead of trying to ignore or forget them: “I think it is about helping me to face up to things, even if they’re bad things.” Related to this aspect of self-healing, participants spoke about the importance self-acceptance: “learning to accept um the way you are” (Allan). Lisa explained that having learned to understand her behaviour, around the events related to her depression, there would be more acceptance: “that I can understand why I did what I did, and you can accept that, and you can live with yourself.” She continues, explaining how liking those parts of ourselves that may be rejected by others was a fundamental goal: “maybe they didn’t want to see that side of you, but that’s who you are”. In this account the participant reported that coming to terms with her imperfections (“the warts”) and acknowledging her efforts to change aided this process: “you are doing what you can to change and you can live with yourself really.” Consequently, Lisa anticipated a symbiotic relationship between acceptance and self-healing

Participants expected the benefits of self-healing to extend beyond their difficulties with depression, being more aware of and resilient in the face of life events: “I think that’s probably what therapy is about, helping you to recognise those and to deal with life” (John). Self-healing was also regarded as a path to self-improvement: “we should hopefully keep on making improvements to make our life constantly better” (Simon). As DiCaccavo (2010) reminds us, Beck intended his brand of therapy to be used as a general approach to our positive development.

A Different Me – Changing Self-perspective

The dialogue with their therapist was expected to enable a new internal narrative to develop:

If it starts that conversation and then it changes that shape of the dialogue which you have for yourself, then you can start I guess experimenting with perceiving yourself in a slightly different light (Allan)

This illustrates how participants may perceive an interaction between their inter- and intra-personal encounters. Consistent with Bachelor’s (2013) *Productive Work* construct, and Midgley and colleagues’ (2016) *Developing New Capacities* theme the function of the therapy was to work towards an alternative self-perspective. Allan conveyed the challenge in trying to achieve a change in self-perspective independently: “It’s the hardest thing to do, is to try to get outside of themselves.” This suggests an expectation that the dialogue with the therapist would facilitate more objective appraisals, as reported

elsewhere (Tambling *et al.*, 2014), thereby supporting attempts to redefine his subjective self.

Participants explained their expectations about how the therapist would help them with this task. Mark, in common with several other participants, anticipated that the therapist would provide an honest account of him:

*It might be a discomfort for me in some ways. I think it should be really.
I think home truths are really. That's why I said y'know I'm willing to
take it on the chin as it were.*

This account illustrates how the process of developing different ideas about themselves was expected to be challenging, abrasive even (Tambling *et al.*, 2014). He confirmed that, “I’m not necessarily looking for a sympathetic experience”, indicating that a more comfortable journey would be a less insightful one. This is consistent with Wahl’s (1999) assertion that people with depression may reject the over-concern associated with sympathy as if it conferred some kind of inadequacy. The narrative suggests that in order to make significant progress with his mental health issues then he would necessarily have to accept hurtful feedback. Lisa expected that this would involve facing undesirable or unwanted aspects of herself: “they’ll give me back warts and all, the truth”.

Participants contemplated the difficulty in managing this challenging feedback. Lynda speculated that she had a potential problem with noticing and accepting such feedback: “Maybe it’s me, I haven’t opened up to, I don’t like paying attention, or something”. This self-doubt was followed by some self-assurance: “maybe I need to hear them.” This account highlights her ambivalence about how constructive it would be to acknowledge feedback which is aversive, in the context of wanting to resolve concerns about her depression. Consequently, the absence of value judgments was seen to be helpful to developing a different self-perspective: “I’m all ears I really am. I’m not going there to be told that I’m right or I’m wrong” (Sarah).

Almost all participants reported negatively evaluating themselves, as part of having depression. Therapy, critically, offered participants an opportunity to test and challenge these negative self-appraisals:

*It's the difference between who you really are and who you think you
are. I don't want to be fooling myself as well as I get older in life (Allan)*

This participant described a mismatch between an expected life-trajectory and experiences of being thwarted by his depression, and had difficulty understanding whether it was realistic to maintain those expectations. The outcome he sought was to be better understand his capabilities: “to have an actual idea of what you can offer”. The self-reappraisal that this would entail was seen as essential to enabling him to address the self-worth issue which was maintained by his problem with low-mood.

Participants identified a number of opportunities from being able to re-examine their self-perspectives. Simon considered the possibility of being able to re-evaluate the severity of the issue he had: “you might actually find that it’s not as big a problem as you think it is”. This highlights his difficulty in being able to objectively gauge how problematic his condition was (see Rogers *et al.*, 2001), which was significant to his perception of how treatable he was.

Need for assistance

A number of participants indicated that there was something missing from their own capacities to deal with their problems, suggesting that the need for help was important: “You know, lots of people go through hard times in childhood and things and do manage to move on” (Lisa). This self-other comparison was used to evidence a sense of ineptitude that others had resolved childhood traumas in a way that he had not. Allan stated his need for assistance: “trying on my own it hasn’t really worked. I need some guidance with the rest of it really”. Thus the function of therapy was seen as a means of completing a process that he had not been able to undertake by himself. Further in the account he indicated that he did not possess the personal resources or understanding that he needed. This was somewhat reflected in a number of other participants’ accounts who expressed concern that they had overlooked or had not yet discovered a key intervention that would help them to make the progress they sought: “maybe I’m missing a trick” (John).

Therapist as Facilitator

Participants expected their therapist to have an instrumental role in facilitating their recovery, and this shares some similarity to Watsford and colleagues’ (2013) theme of *Directiveness*, which concerned expectations about the therapist’s level of involvement. In common with a number of other accounts, a directive style of facilitation was sought by Lisa who expected to be instructed how best to manage her depression: “I am looking for somebody that’s going to tell me, look, this is what you need to do.” Michael similarly

envisaged that the therapist would introduce and demonstrate different approaches, and explain how to apply and refine them: “show them different things to do, how to do it, how to improve something, and deal with situations.” These accounts provide further evidence of expectations of a hierarchical relationship with the therapist (see Midgley *et al.*, 2016). They support existing research indicating that some clients may seek a non-collaborative experience (Westra *et al.*, 2010).

Michael stated it was necessary for there to be a leader in the therapeutic relationship in order to provide direction: “there’s got to be one person that’s leading the way.” Emma anticipated that in this leadership role, the therapist would provide structure and prompts: “some boundaries, something to then open up to, something to expand on, but to be led there first.” In this account, a part of the therapists’ role would involve providing an environment in which the therapeutic dialogue is contained (Howard, 2010).

Most participants regarded guidance as a requirement. For Adam, this reflected a reluctance to be independently problem-solving his issues given his past difficulties in trying to effectively manage depression, “And not have to try and work out a lot of it for myself”. Participants expected the therapist to guide the exposition to address the important issues:

Try and guide the sort of train of thought down the road they probably think that you really need to explore, without actually y’know sort of cattle-driving you down there (John)

In this account the therapist was expected to prioritise the direction of the exploration, whilst managing their power and influence. This speaks of a more person-centred, rather than a patriarchal, style of guidance-giving. Consistent with this account, Gareth explained how his experience as a teacher highlighted the potential limitations of the therapist’s influence: “all you can do really is guide your students or your client or your patient” This Rogerian-esque (Rogers, 1961) expectation indicates that therapists cannot govern their clients’ behaviour, as they make their own choices.

Participants expected that therapists would use their expertise of mental illness to guide the therapeutic process: “they know the mental side of it so they will be asking the right questions” (Emma). The significance of this was explained by Allan, who expected that receiving this guidance would encourage him to explore challenging issues which might ordinarily be avoided: “I need someone else to guide me through that process, nobody really wants to engage with a lot of these deeper things.” As with previous accounts,

participants expected to have to provide material to be worked with (Midgley *et al.*, 2016), and a need to go beneath the surface content of the problem initially presented (Tambling *et al.*, 2014).

Some participants, like Michael, expressed faith that their therapist would have the capability to facilitate their recovery: “they are trained, they know what works and what doesn’t work”. Participants regarded the therapists’ status as a mental health professional as conferring some form of authority for the guidance they might provide. Some participants also anticipated that the therapists’ status would confer responsibility for the outcome: “if anything happened which made things worse I would probably go well the therapist was obviously an idiot” (Simon). The significance of having a capable therapist was highlighted by John, who expressed hope that he would be, “with a good therapist.” Were this not to be the case he expected that he would be referred onto a more competent therapist: “if that particular therapist can’t deal with it they would then forward it on to someone who is more qualified.” These accounts convey a concept of the therapist as the ‘more powerful other’ (Maier & Straub, 2011), indicating that an external locus of control, which may play a part in their depressive symptomology (Richardson *et al.*, 2012), may also contribute to their expectations (Moses *et al.*, 2007).

Teach Me – An Educational Role

Participants expected that a distinct task of therapy was to educate and advise them. Some participants related to therapy as though it was education: “I suppose it’s like any course really” (Michael). Most participants’ accounts highlighted a thirst for knowledge that would facilitate their understanding of depression: “it’s just simply I need more information and here’s another place of getting it” (Simon).

The therapist was anticipated to have extensive knowledge on the topic of mental health: “someone who has done a lot of research and who is hopefully knowledgeable on this subject” (Simon). This is comparable with how students might expect their lecturer to have a good knowledge of their field of study. In this role, participants described a variety of knowledge and skills deficits they expected to be taught. Emma outlined how having information about working effectively with their mental processes was essential to improving their wellbeing and overcoming an impasse: “I guess that’s where we don’t have the mental knowledge.” Sarah expected to learn about lifestyle issues affecting mood: “diet probably, teaching different foods that might help you.” Some participants

desired this more didactic support, distinguishing it positively from a more reflective style of facilitation: “they are not necessarily active in the discussion” (Gareth)

The significance of the educational role was explained by Michael: “if you get a good teacher you then you can become whatever you want.” This account highlights a narrative that education facilitates opportunity, and hints at the possibility of self-efficacy having a key role in this (Williamson, 2015). Accordingly, the notion that depression can be overcome by learning knowledge or skills breeds a sense of optimism.

An active and willing client

Many participants reported that they should be expecting to give therapy a go and be an active part in making it work. James considered that the act of help-seeking obliged them to utilise the help given: “they might say well how come you sought out this treatment if you’re really not willing to engage with it”. This account evidences how participants might anticipate being admonished for poor engagement, suggesting that they hold expectations that mental health professionals will hold negative attitudes toward them (Pill *et al.*, 2001). Such expectations potentially fit with broader concerns about help-seeking, in particular, how they anticipate being blamed and criticised for the difficulties associated with their depression (Barney *et al.*, 2009). Lisa hoped that therapists would overlook certain aspects of their behaviour if they could observe a willingness to change: “what you’re saying isn’t right, but I see that you want to change.” In common with other clients, she expressed high desire to change: “I want to change, I want to”. This is consistent with other accounts citing expectations of readiness (Watsford *et al.*, 2013).

A number of participants expected they would be required to demonstrate a commitment to therapy: “in my capacity as a manager in work, what I expect from people when they come on is a commitment” (Michael). Allan explained that this commitment would entail being receptive and attentive to the therapists attempt to support him: “open mind, anybody who’s trying to show you something, they want you to um take notice, do the best you can.” The latter part of this account reflects an expectation of investing what efforts they can, potentially reflecting feelings of responsibility. As Emma indicated: “I guess it’s all down to me, what I put in is what I get out. I know that, I’ve always done that”. Where participants presented such attitudes, they appeared to be connected with a burden of responsibility around having depression (Barney *et al.*, 2009). This seemed to negate the self-serving bias in a way that might exacerbate the sense of failure associated with the condition (Taylor & Brown, 1988).

Participants expected that their therapists would require them to try to undertake all the tasks of therapy: “I imagine they expect you to be quite willing to comply” (Michael). For James, being compliant made it unacceptable to challenge an activity they had been directed to complete: “[they] set you something to do and you say “know, that’s absolute rubbish”, and that’s no good to them.” According to the theory of reasoned action, intention to engage in therapy would be a reflection of having a positive attitude towards it (Halgin *et al.*, 1987). Nevertheless, some participants reported that their expectations of being active and willing were not dependent on being certain of improving: “Honestly I don’t know if things like that will help me but I thought I’d explore every angle now” (Lisa). For this participant, her willingness to engage in therapy reflected her eagerness to find a solution by investing in any opportunity available. This was associated with an expectation of needing to try to meet this objective through a try-all approach: “it’s all trial and error, I know of that, but I’m willing”. This is consistent with research indicating that expectations of having commitment prevail despite the difficulties anticipated (Elliot *et al.*, 2015).

Having positive expectations for therapy was another way that participants demonstrated their willingness to engage with therapy. Simon expected to be more positive in his thinking: “Yeah, we’re gonna do something about this.” This evidences that participants intrinsically see value in positive self-talk, and may be further related to their sense of self-efficacy (Hardy, 2006). It may also reflect past experiences of being thwarted by self-doubt: “I’ll try and stay positive and confident about what’s going to happen.” The narrative in these accounts indicates that this is how participants attempted to stay willing in the face of the difficulties associated with depression. This extended to trying to maintain positive expectations for the therapist: “as long as I keep that this is a good person, this is going to help me kind of thing, then that will be fine” (Emma).

THEME 5: Finding a good helping relationship

This theme captures how participants saw a good helping relationship as being imperative to the possibility of recovery taking place (Bachelor, 2013; Beattie *et al.*, 2009; Woolfe, 2012). It shares some similarity to the overarching theme of *receiving adequate therapy in a collaborative therapeutic relationship and recovering* reported by Paulson-Karlsson and Nevenon (2012).

Positive Relationship

Participants considered the importance and qualities relevant to a positive relationship with their therapist. Adam pondered these issues: “Will I be able to open up to her? What will she be like? Will she be pleasant? Will she be helpful?”. This account revealed an uncertain stance, and being able to disclose his problems was expected to be dependent on how the therapist approached the relationship. Simon reported that the need for a good relationship was to help with managing potential feelings of vulnerability: “there’s the risk that people might feel vulnerable”. A positive relationship would provide the necessary containment to explore sensitive issues relating to their depression.

Therapists were expected to help through a professional attitude: “they’ll be professional people so it will be fine.” (Emma). This was described as conferring a number of positive qualities to the relationship. Referring to his experiences at a hospital service, Michael explained that a respectful approach signalled that his concerns would be treated seriously: “[they] were very helpful; nice, polite and courteous”. A number of other clients expected the therapist to behave in ways that are associated with being professional, such as punctuality: “in practical terms, to get there on time” (Mark). These issues were associated with the quality of the help they would be receiving, and in particular, for Mark, the quality of care: “if they ain’t going to be there, they don’t care”. This conveys a sense that the availability of a therapist would demonstrate that they were invested in them and had their interests at heart. For Lisa, this was instrumental in previous instances of help-seeking: “she was right there, I felt like I could tell her.” She reported that her advisor helped from within the professional role that she had with her, which was not complicated by the closeness in her family relationships: “she was keeping her distance as my advisor”. It fulfilled her need to have someone to convey her problems to: “she did what she had to do and she listened.” Sarah similarly expressed gratitude that her helper managed the boundaries of their relationship: “neither did the doctor try to be my friend.” These accounts appeared to be consistent with research which indicates that a barrier to disclosure is health professionals who have a non-professional relationships with their clients (Emslie *et al.*, 2007). Lisa indicated that receiving professional help was less conditional in nature: “although maybe she may be did think I don’t agree with that, she did keep it sort of professional.” That she did not agree with or condone how the participant had been did not affect whether the sought-after help was given, as might have been the case in her personal relationships. In this way, a professional relationship offered her continuity: “I would want her to say, ‘that’s not the way it is’. But, in that as

well, 'I still want you to see me the next time'." These narratives illustrate how meeting a therapist within a professional role could give them confidence that they will secure the help that they want. The importance placed on this potentially relates to the possibility of being able to explore their issues in a context that is less tied to feelings which have its origins in transference (Philips *et al.*, 2007).

Factors relating to the therapist, and their ability to relate to them, were seen to be relevant to a positive relationship (Tambling *et al.*, 2014; Watsford *et al.*, 2013). Adam considered that the therapist's role entailed being a good communicating-partner: "she wouldn't be doing her job if she wasn't an approachable person." Michael sought someone who could convey information well: "just sort of put their-selves across to you." Numerous participants spoke about the importance of developing a rapport, with Michael regarding this as being universal to our social lives: "It is in all life, to connect with someone." Emma anticipated that the rapport would help her to overcome her anxiety about making disclosures: "I'll be very nervous at first I think but you just get a connection and then just go with it." Adam pointed to the importance of likeability: "somebody you're gonna be able to like." He explained that this occurred at an emotional level: "I know at times you can get a feeling about somebody whether you want to or you don't want to". Similarly, participants foresaw the need to be well matched with their therapist, with Allan indicating that this was significant in terms of generating mutual understanding: "it is just sometimes down to chemistry sometimes. A person either gets you or not." Given the participants' experiences of being misunderstood by others and of having difficulties understanding themselves in relation to their condition, therapy would necessarily need to be a joint venture in meaning-making (Anderson & Goolishian, 1992; Lewis, 2015). These accounts further highlight the importance of a bond with the therapist (Bachelor, 2013).

Many participants expressed the importance of feeling comfortable with their therapist, as this was equated to being able to trust them: "well I hope that y'know that someone who I feel comfortable around them like someone I can trust" (Mark). This corresponded with others' reports that if they did not feel comfortable they would have difficulty being open: "if I feel I am in a situation where I feel uncomfortable the words would not come forth" (James). Similarly Lynda speculated that she might not co-operate in these circumstances: "maybe I'd want to hold back, basically resist it a little bit." The above accounts are consistent with expectations of therapists being friendly and comfortable to

be with, as reported in other studies (Tambling *et al.*, 2014; Watsford *et al.*, 2013). Such expectations could reflect positive attitudes toward help-seeking (Halgin *et al.*, 1987).

Some participants expected that a positive relationship would develop over time. Knowing the person enabled participants to understand whether they could anticipate a judgemental response: “I haven’t met them, it comes back to judging then doesn’t it” (Michael). Consistent with this, Simon anticipated that the therapist would offer a non-blaming experience, as he did in his work role: “they have to build up that confidence that I’m not going to be blaming them”. He continued, explaining that having a person’s confidence was of paramount importance: “anything they say is in confidence, I’m not going to go to their boss, ‘well they fucked up’.” The narrative in these accounts highlight the importance of having an established rapport in which the disclosure of personal difficulties is facilitated by a confidential and non-judgemental relationship, making feelings of vulnerability more manageable (Clement *et al.*, 2015).

A number of participants carried expectations that positive relationships would be fostered through caring and kindness. A recent placement-related experience informed James that others could potentially help him to engage with undertaking novel tasks, including the task of therapy: “I had never done anything like that and they were a very kind to me.” Participants expected their therapists to offer reassurance: “saying ‘it’s fine, don’t worry about it’” (Simon). These accounts highlight how the quality of caring was regarded as a way of cushioning them from the anxiety of trying to meet the significant challenge presented by therapy.

A number of participants considered what they would be required to contribute to a positive relationship. Michael considered that they would need to be able to convey information well, just as they expected from the therapist: “just sort of put their-selves across to you, and relate to you. And that goes both ways too.” Allan indicated that being open and communicative would enable them to fulfil an expectation of needing to provide substantive issues to be worked through: “Well I’m pretty open and I’m pretty talkative so I think I’m probably fairly good material y’know for someone.” This account is consistent with existing narratives about what it means to be a good enough client (Iwakabe *et al.*, 2000). Several participants anticipated being able to establish a working relationship: “I do find a rapport with most people” (Sarah).

Like other participants, Adam was worried and anxious about the possibility of the relationship being poor: “There’s a lot of that, what happens if I don’t like her”. If their

relationship the therapist did not work, participants expected to face uncertainty about their options. Given that the relationship was regarded as significant to their ability to make progress in disclosing and exploring distressing concerns, as well as managing their vulnerability, this was deeply concerning for participants. For some participants, this issue of relating would determine their response to therapy:

I think a lot of it is gonna depend on who the therapist is and if it's not working I'll know pretty much instantly and I'll just say "I'm sorry"
(Mark)

In this account, relatedness was expected to be judged instinctively, and concerns would be need to be communicated. Some participants explained that it was a manageable issue, for example, Simon speculated that he would be able to see another therapist: "it might be that I'd just go and see someone else". Overall, Allan did not think it would hamper his expectations of whether therapy could be helpful: "I'd like to think it wouldn't put me off therapy".

Responsiveness

Michael emphasised the importance of being able to get help tailored to his individual needs: "As opposed to just going through life and treating everyone the same." In this account, the concern reflected how an individual's needs could be misunderstood and inadequately met, as is reported elsewhere (Beattie *et al.*, 2009). Concerns that his treatment would be ineffective were expected to be ameliorated by the therapist obtaining a comprehensive understanding of the clients' problems at the outset:

I mean they've got to understand what you're going through first of all, it's no good if they try and treat you one way and you really don't need that treatment but like a different kind (James)

Participants anticipated that a therapist having a good listening skills was imperative to this: "I would imagine that on top of actually being a good listener" (Gareth).

Relating to his experiences in work, Simon considered that while it would be easier for the therapist to provide solutions without consultation, failing to take the person and their circumstances into account would have implications for the person's acceptance of it: "if I can come up with the solution that actually works with the person and their environment, than forcing them to do it a different way". Therapists were therefore expected to involve them in decisions concerning their therapy. Reflecting on his experiences of being helped

by his doctor, Adam anticipated he would have a choice of proceeding with any approaches suggested, having received an explanatory rationale beforehand:

It's 'this will help you, if you're happy with it, go ahead'. It was like that rather than being told, 'this is what is wrong, this is what you've got to do'

This collaborative position improved his disposition towards engagement. Specifically, his willingness to undertake tasks improved when he decided to proceed with them, compared to when they were completed to pacify others.

Some participants anticipated contributing more actively to the therapeutic process. Allan explained how he hoped to work with a therapist who was able to mirror his more organic-style of decision-making: "I'm quite an instinctive sort of person anyway so I appreciate that somebody else is sort of being quite instinctive about the situation". He continued, explaining that this might involve the therapist being flexible with how the therapeutic approach was applied: "not necessarily go through all the correct manoeuvres as it were". This account indicates that he expects the need to adopt an endorsed approach to be balanced against his own needs. Participants wanted to have regular opportunities to discuss their progress and provide feedback: "there's going to be a review in the next session on what you've done and if it's helped you at all" (James). The participant anticipated that this would enable the content of sessions to be adjusted according to his experience of therapy: "if something was really not working for you then perhaps you work on that one a bit longer." Therapists were expected to take into account participants' various issues: "maybe there are other things going on as well" (Allan). Michael identified the potentially symbiotic nature of the relationship, in which they would be enabling the therapist to support their own individual needs: "it'll be the same with the therapist, help them to help me" (Michael).

Were James to experience difficulties meeting his objectives, he anticipated continuing to try to orientate his therapist to his needs: "I think I would go on for a wee while trying to explain what I wanted." Participants therefore anticipated that they would have influence and that a responsive therapist would pay attention to their expectations and feedback. These expectations for a collaborative model of a relationship are consistent with the *Therapy as a Relationship* theme reported by Midgley and colleagues (2016).

OVERARCHING THEME 3: HOW TO DEAL WITH DEPRESSION

The second overarching theme captures the way participants grappled with ideas about how therapy would actually enable them to handle their depression. Participants had seen themselves and their projected future lives change through their depression, and they wanted therapy to rectify these unwanted deviations. The experienced loss of agency through depression was so significant that participants tussled with issues of control and elimination. It also juxtaposes how participants considered the possibilities of a “quick fix” up against long-term ways of managing depression.

*It's a really hard one to explain, it's just being you, that's who you are,
that's where you wanna be, that's where you've been all your life, and
that's where you want to continue to be and I'm not that person any
more* (Michael)

There's always going to be a problem, um, just how do you deal with it?
(John)

THEME 6: Understanding how to get back on track

The outcome of being restored to a previous iteration of themselves in which they were functioning as expected was a commonly expressed conception. Participants envisaged that this might happen by identifying and working through factors that were seen to be responsible for the origins of their depression, and by exploiting explanations about its onset.

Origins

Participants expected that therapy would help them move on by tracking their depression back and identifying its origins: “I think my next step will be letting everything out, and getting to the root cause of my depression” (Emma). This account suggests that exploring their experiences would serve this purpose. Finding a valid context to their depression could make it less likely to be subjected to being stigmatized (Jones *et al.*, 1984). Several participants anticipated examining their formative years: “go back to my growing up” (Lisa). Some expected to find answers by discussing their family context: “I want to try and find out if it was my past, my upbringing and things” (John). These ideas echoed a common thread in participants’ narratives that their present concerns were directly linked to their early experiences: “I would imagine a lot of stuff I mean y’know must go back to childhood” (Allan). Allan revealed a sense of being haunted by unresolved past issues:

“you can push stuff away but it’s always coming back. You never really exorcise this stuff from the past. It’s a continual process.”

Participants anticipated being able to probe existing ideas about the origins of their depression, with a number identifying family relationship problems: family relations being closed and secretive, poor emotional expression and literacy, a lack of affection, unfulfilled relationships with their caregivers. Sometimes participants had expectations of examining speculative issues, for example, John considered that it would be important to know more about the impact of birth order in his issues, having read about this: “possibly being second sibling, just stuff I’ve read and been aware of really.” This illustrates how themes in popular psychology may influence participants’ perceptions of what psychological support might entail (Doss *et al.*, 2009).

These accounts indicate that participants anticipated learning to understand how their experiences contributed to patterns of relating, to themselves and others, and therefore influencing to their low mood (Granek, 2006):

I’m just seeking some professional help to change that dynamic I guess because I’m hoping that once the knowledge is there as to why, and we do a bit of digging as to why I feel like this (Emma)

The exploration that participants expected to take place in therapy, would serve to excavate the answers they sought, about the context in which their mood was originally affected, so that the patterns associated with their difficulties would not continue to be repeated. Lisa explained that establishing the nature of the difficulties experienced in past events could be used to improve her coping with her current predicament:

The things that happened were the things that were affecting me at the time. Now it’s different things that are affecting me but I need to take what I’ve learned from there to the new place or point in time.

The Tipping Point - Causes

Participants expected to discuss explanations about what might have caused the onset of their depressive episode: “I think that was probably the tipping point, as I say, the beginning of that point” (Allan). Like the narrative around understanding the origins of their difficulties, understanding the causes of their depression in therapy was also expected to be part of obtaining solutions to overcome it: “understand what’s wrong, what’s the trigger, and then how to corrected it all” (Adam). Participants posited a wide

range of triggers from biological catalysts, stressors relating to their relationships, finances, work, and health situations. Occasionally participants experienced the emergence of their depression through a loss of coping: “[I’ve been] using methods to cope with it in the past, but um I think it’s accelerated on now beyond that” (Michael). Some participants reported uncertainty about the causes of their depression: “just trying to find where those emotions come is, I don’t know, hard to find” (Mark). Participants expected to be able to learn to be more aware of their own low-mood triggers: “when you apply the same rules to yourself, you start realising what varies and that there are things which influence you on a daily basis” (Simon).

Off Track

Participants reported a sense of their lives deviating so that they are now not how they ought to be: “understand what’s gone wrong, how to try and get back on track” (Adam). This account illustrates how depression is experienced as a fault that is unacceptable. Many participants wanted therapy to return them to a state of being how they had been previously: “returning back to how you were” (Michael). This is evidenced in accounts elsewhere (see Midgely *et al.*, 2016). Participants’ related this expectation to their identities, in that depression had prevented them from being their true selves. By remedying their depression they anticipated being able to entirely recover to this state: “if my feelings of depression subsided and [I] return to myself” (James). This account highlights how participants regarded a previous experience of emotions as their normality, and that they needed to default to this. Allan said therapy was one of a number of different attempts to try to return to a state of being he had previously experienced: “I did cut a lot of other things out of my life because I was so desperate to get things back on track really.” That these deep psychological problems inhibited his progress was viewed in terms of how he previously saw himself and in terms of where he believed his future lay: “I’m not getting to where I could be, or where I’ve been to before”. The concept of depression being rooted in loss (Budge *et al.*, 2013) is echoed in these comments – the loss of past ability and a loss of future aspirations. Occasionally participants spoke also of a loss of self, as is highlighted by Allan’s expectation that he would: “try and engage with that part of me which for some reason isn’t there anymore.” Midgley and colleagues (2016) posited that this desire to have their old selves back enabled clients to hold a more transient view of their depression. It may also reflect a part of their counter-productive coping strategies (Goldfarb, 2002), which obscure an opportunity to form a more realistic view of themselves (Kernberg, 2009).

THEME 7: Whether to control or eliminate depression

This theme captures how participants sought to manage depression, which was related to a loss of control, mentally, emotionally, and behaviourally. Most participants sought control over their depression, and having conscious control over their mental processes and adopting practical strategies were regarded as potentially useful ways of doing this. Some participants responded to the loss of agency by seeking to cut themselves off from their depressed experiences. The theme also examines how magical solutions that eradicate depression sat alongside ideas of managing depression as a potentially life-long condition.

Conscious Control

Participants expected to develop an oversight of their mental processes to manage their depression, in therapy. Attributions of the controllability of depression are potentially a feature of stigmatisations (Barney *et al.*, 2009), and this might reflect some internalization of this. Participants spoke about the importance of having conscious awareness of thoughts in order to exert mental control:

The more alert you are, the more you are able to take control of yourself basically, um sort of semi-conscious (Michael)

This account highlighted a need for vigilance, and the purpose of this was explained by James as the, “identification of what is happening to you [which] is like the first step”. Therapy was therefore anticipated to be highly analytic, dissecting depression into its constituent processes: “talking through things and actually analysing the smallest thought processes” (Allan). Simon expected to improve his knowledge of both the mental processes and the context in which they occur:

You actually need to understand not just the problem but everything around it, the processes that are involved, the reasons why they got to that situation

These accounts illustrate how participants’ mental processes were often experienced as something independent of themselves. That therapy was seen to have a role in looking beyond the symptomatic thoughts and helping them identify causes was echoed by others, citing the importance of knowing and circumventing any precipitating events: “avoiding the triggers or knowing when the triggers are coming upon you” (Adam).

Therapy would also serve to help them to identify cues relating to unhelpful thought processes: “finding warning signs and being able to nip things in the bud” (Allan). These narratives suggest participants were anticipating being able to learn ways of coping that involved avoiding and preventing aversive mental processes.

Some participants expected that the conscious control of their mental state could be achieved by changing their thoughts: “correct myself by my thoughts” (John). James explained that he anticipated doing this by trying to develop more constructive ways of thinking, such as considering positive alternatives: “trying to develop positive thoughts”. He also expected to be able to more accurately evaluate his thoughts: “kind of say, ‘hold on, is there a basis for this, um, is that really the case?’.” The strategies being described are consistent with a cognitive re-structuring approach (Beck *et al.*, 1979; Beck *et al.*, 2003), which he had learned about in self-help material given to him by his friends. His difficulties applying the strategies indicated a supporting role for therapy in helping him develop the strategies and overcoming any barriers to their use.

Participants reported a number of factors that were further expected to help them to develop good awareness and control of their depression. For Allan, detailed decision-making was instrumental:

Become aware of the sort of minutiae of choices that you make every day. Not the big choices in life. And then you have to kind of stop that thought, just nail it there, “no I’m not going there”

In this account, significant life-choices such as moving house or getting married were seen to be less relevant to his low-mood than moment-to-moment choices about how he thought. It highlights a determination to halt detrimental courses of thought, helping to reduce the severity and duration of his depression.

Improving their ability to manage unhelpful thought processes in these ways was expected to yield a greater sense of agency over their mood. Sarah said, “it will be that first step to then understanding how to control emotion, because I think the emotion bit is massive.” This account underlines the objective of ultimately managing their emotions, along with a sense of the task being a sizable one. This challenge can be understood from Lisa’s description of her emotional-based reactions:

You’re ignorant working because you’re not consciously able take the two sides if you like, and balance them. You are just flying off the handle or making decisions just randomly

Her responses were experienced as involuntary, denying her the opportunity to acknowledge and consider different perspectives, and make more deliberate decisions. Mark similarly stated that the main outcome that he sought from therapy was to overcome an automatic tendency towards emotional reasoning, and acting on it: “When my thoughts in my mind are no longer taking over. I want to stop doing the random things and I’ll feel comfortable with myself.” These accounts illustrate the sense of self-dissatisfaction that participants felt about the way their low-mood modulated their thoughts and behaviour, and role therapy would have in attaining an improved sense of control (Reynaert *et al.*, 1995).

Mopping it all out – A Disabled Mind

Some participants spoke about wanting to cope with depression by exploring various ways of shutting themselves off to their mental experience. Lisa described wanting to cleanse her mind of the depression:

Just wanting to go inside your head and mop it all out. And you just can’t do it, you can’t get in there to clean it away. You have to wait for time

This highlights many participants’ desire for someone to come and eliminate the problem. The analogy suggests that thoughts and feelings associated with a depressed mind-set are judged as soiled, dirty or a mess. There might be a risk of depressed thoughts and feelings spreading, like bacteria in unclean places, if it is not completely eradicated. As desperately as this fantasy was wanted, it was not seen to be realistic. Instead, she finds herself having to resort to being patient, as she invests in an idea that depression will diminish with time.

Many participants reported using mental and other strategies to disable their experience of depression, in order to achieve emotional numbing. Emma described being closed indiscriminately to all emotional experiencing:

By shutting off from everything it will stop my anxiety and stop me feeling sad. If I cut off the feelings and go into that little emotionless bubble

This account illustrates how the strategy of being shut off to their emotions, both negative and positive, has a protective function akin to an electrical cut-off, in a way that is potentially distancing. Emma explained the priority was to manage emotional difficulties and this had been achieved by refraining from expressing or receiving emotion:

“it’s just not wanting to smile or show any emotion or feel [emphasis] anything, I don’t want to deal with it”. Participants reported averting other internal stimuli, including their cognitions: “I just cut it off and think about nothing” (John). Triggers for internal events were also reported to be avoided, including social situations: “I choose not to interact, I just would rather have no feelings” (Lynda).

Some participants, such as Lisa, reported expectations of receiving some intervention with an objective of being able to clear their minds of its distressing content:

I wanted somebody to either say something or give me something that would take away the feelings inside, take away everything that was going on in my mind

In this narrative the participant does not regard herself as being an active part of a therapeutic process, instead it might be done to her, reflecting difficulties attaining an internal sense of control. Lynda’s expectation for therapy appears to be an extension of this idea. She reported that therapy would provide an opportunity to jettison some of her inner turmoil by talking about it, in effect, giving it all to the therapist: “just having that out, instead of having it in, as I have always had it in”. This is consistent with the expectation that therapy would ‘take away something painful’, as reported by Midgley and colleagues (2016, p.17). Lynda reflected how diverting her attention away from her distressing thoughts and feelings had become the default coping strategy, at the expense of working through them: “it’s quite easy for me to switch off, but I know [emphasis] that I should face all of the bad, but I just don’t”. This highlights the issue that the challenge in going for therapy lies in having to come to terms with the possibility that the solution might involve exposing herself to her distressing internal experience (Abramowitz & Landy, 2013).

Strategies

Participants often reported an expectation of obtaining coping strategies in therapy: “just putting mechanisms in place whereas you’re more able to cope with it” (Michael). This highlights expectations that therapy involves activities other than talking through problems (Arch & Craske, 2008). Simon anticipated there being a role for coping strategies in helping him to manage the depression if it did not subside: “I should hopefully have less of the problems that I experience um, or that I find ways of dealing with them, so maybe the problems are still there.”

Participants typically had difficulty anticipating in more detail what or how coping strategies would be developed in therapy. This is similar to previous reports of the vaguely expressed expectations of receiving help (Watsford *et al.*, 2013). Commonly, participants' accounts about learning strategies would involve non-specific statements: "I've been told certain techniques and stuff like that, probably exercises" (Michael). This account illustrates how these sparse expectations may have formed anecdotally, from information received from others. Gareth was the only participant who made reference to using a particular therapeutic approach to develop coping strategies: "getting along and learning a bit about mindfulness". The participant was uncertain about what form the strategies in this therapeutic approach might take.

Occasionally participants expectations were based on advice from their family members, friends and colleagues who also had depression, and more frequently from their doctor: "there's quite a few techniques that that the doctor has mentioned, about breathing even" (John).

A few participants anticipated being able to develop strategies for dealing with specific problems experienced with their depression, for example, Gareth expected to learn ways of coping with sleep: "exercises really in how to sort of try and combat certain aspects like not sleeping."

Participants' expectations of learning coping techniques in therapy were also based on their experience of attempting new ways of coping themselves:

When they are down, just go for a walk or something and come back into the situation they could cope with it a lot better, you've got a different mind-set then (Michael)

A few participants described expectations about how they would learn coping strategies. Emma hypothesised that they would be elicited naturally from the therapeutic dialogue:

And it makes me understand, why don't I go and familiarise myself and then I might be more confident. Simple things like that, I've now built up just from our conversation, are coping mechanisms

In this example, furthering her understanding of problems with low confidence about being able to perform adequately, helped her find a coping strategy of familiarising herself with the situation beforehand. Gareth anticipated learning a series of coping strategies, each advancing on the previous: "It's a step by step progression". Both

accounts suggest a developmental narrative around learning coping strategies and highlight a need to undertake and extend therapeutic work at the level of their knowledge (Denman, 2001).

Participants typically expressed a positive outlook about the prospect of developing coping strategies. Michael drew on his own positive experiences: “I’ve had some people telling me techniques and stuff to do and they’ve helped so I am excited.” He had also observed others’ well-being improve through their use: “they use techniques as well, and they are seem to work”. Some reservations were expressed about using coping strategies, for example, Sarah was concerned about her ability to employ those coping strategies known to her consistently: “Just these little things you know, and I can’t do it all the time”.

SUBTHEME 7.1: Magic Solution

This subtheme captures the possibility of being completely problem-free, which was mused by almost all of the participants as they considered whether therapy could offer them a magic solution. Participants reported general expectations for positive changes in mood: “it would make me happy” (Allan). Expectations of achieving a complete recovery from depression were also reported: “I’ll be able to get over it, I’ll be able to leave it, I won’t be facing those horrible things” (Emma). All of these accounts suggest a narrative of overcoming depression and of being fine in themselves thereafter, as is consistent with widely held beliefs (Corrigan *et al.*, 2000; Crisp *et al.*, 2000; Jorm *et al.*, 1997). Depression was therefore regarded as the problem that needed to be resolved: “you start thinking about OK what can I do to fix it, not just for myself but for others” (John).

Many participants questioned whether they would recover from depression: “Maybe there is no explanation, there is no cure, you just have to work through it each time” (Lisa). The possibility around obtaining a rationale that leads to a permanent solution was contrasted less-confidently with the prospect of needing to cope with depressive episodes. Mark stated that some psychological concerns would be more amenable to recovery than others: “some psychological things can be fixed but a lot of them can’t.” He continues, “I would be very cautious of saying there is a solution to problems”, indicating that expectations about resolving mental health issues could be unrealistic. Lynda similarly presented a less polarised view around the prospects for recovery in depression: “I don’t think there is a miracle cure to be honest, I don’t think people fully recover.”

Indeed many participants were eager to dismiss the concept of a complete solution to depression: “I don’t know what a cure would be and I think it would be stupid to ever think that that’s even possible” (Simon). Using an analogy about wanting a life in which all our wishes fulfilled, Simon highlighted the fantastical nature of hoping there was a cure for his depression:

There’s this world of paradise that everything’s going to be perfect, that you’ll be lying on a beach at the perfect temperature, you put your hand out and you get a drink immediately or whatever, it’s not going to happen

Talking about people who present themselves to their doctor, with mental or physical health concerns, he argued it was possible to challenge the notion that many issues were completely remedied: “they get a tablet which will solve whatever problem they have um, and this is a belief that is largely untested or unchallenged.” In this narrative, health problems might not be fixed or cured, and so treatments may just help them to cope with them. Some participants’ expectations for therapy were consistent with this: “just talking about it is useful, but it’s not a cure” (Gareth).

Simon consequently stated that mental health professionals should avoid giving clients expectations that suggest that they will be magically transformed in therapy:

Psychologists should be saying we’re not going to give you a magic solutions, we’re not going to just sort of um y’know just turn a key and all of a sudden everything’s fine

This account indicates that they would more helpfully explain that improvements in therapy may take time and require considerable effort. The importance of clients having realistic expectations for positive outcomes in therapy is well documented (Richards *et al.*, 2003; Watsford *et al.*, 2013).

Some participants questioned whether completely eliminating depression would ultimately be advantageous to them (Ridge & Ziebland, 2006). James pondered the possibility that it conferred some positive qualities: “Is it a negative, like imagine that this enhanced my ability. Who knows maybe it does somehow.” While this account was highly speculative, a number of participants were more specific about the impact that might be experienced by eliminating depression. John explained that supporting people to overcome their low mood could be detrimental were they to be encouraged into activities that they are not comfortable with:

You may actually be affecting the person entirely, they could go off and do something which they didn't necessarily want to do in the beginning

This account suggests that depression could serve to deter them from engaging in activities that they are not suited to. According to this narrative, the process of reducing barriers to activity in depression needs to be undertaken delicately and collaboratively, in respect of the individual's needs and abilities (Martell *et al.*, 2013). Together these narratives explain how the protective function of depression might have validity in their lives as a whole (Ridge & Ziebland, 2006).

SUBTHEME 7.2: The ongoing battle and indefatigable me

This subtheme captures the possibility that relentless effort would be required to achieve a more consistent way of being. Mark expressed uncertainty about what role therapy would have in supporting him:

I'm not sure if it's viewed that people who need therapy will never fix their problems then that's an ongoing thing that you're going to have to have throughout the rest of your life

This participant identified that an incomplete solution to his depression could result in it being ever-present in his life. Emma agreed: "gradually over my years I have completely known that um there's no quick way of doing anything". Emma continued: "there is a short, snappy, snap out, but that doesn't fix it, at all." Experiences had crystallised her perspective that short-term ways of managing her mood left her with an underlying and unresolved life-affecting issue. These accounts highlight how they were actively trying to establish appropriate expectations for therapy, in respect of their depression.

Many participants reported expectations of needing to continuously apply strategies: "The bad thing is maybe there is no cure, you just have to work through it each time". Compared with the preferred outcome of therapy providing a cure, the alternative could appear to be effortful, and would place the onus of recovery on the participant. Progress was seen to be a gradual process by James: "that doesn't come across to me as something that will immediately have an effect from something you work on". Adam highlighted the arduous task that was anticipated in therapy through a parodied scenario in which a casual conversation with the therapist has the effect of magically elevating the client's mood: "it's not a matter of sit down with a cup of coffee with somebody and hey ho, I'm

going to be jumping around”. James normalised the investment that might be required to achieve the desired outcomes in therapy: “you have to work for anything to get some results, that’s real and reasonable.” The effort required was posited as a realistic expectation on the basis of a narrative that people are responsible for creating or earning their success, through continuous hard work.

Participants expected to deal with challenges in making progress in therapy. Sarah explained it needed to be given an opportunity to work: “You’ve got to give it a bit of a chance. Yeah it helps with time.” The effects of therapy were not expected to be direct – that action leads to reaction – rather a more subtle process was suggested. As a consequence, managing expectations and potential setbacks was given reverence. Speaking about how he would respond if therapy was unhelpful, James reported a comparable expectation: “carry on with it, sometimes you might not notice results to begin with and it takes a bit of time.” This account further illustrates how participants shared a notion that positive outcomes may not result from a linear relationship with the amount of therapy engaged in. These participants’ accounts share similarities in the narrative, that therapy would not be an exact science and of time being a healer. As with the last account, participants expected to need to be steadfast in persevering with therapy. Michael anticipated that that therapy, like courses of learning, would require determination: “There was a lot to learn, there’s more mundane stuff that you’ve got to deal with and that’s when it gets hard.” Explaining this comparison, he highlighted how expectations could initially be high, but as the learning progressed, the more intricate or technical aspects might dampen his motivation.

In therapy, Michael anticipated difficulties applying the learning appropriately: “battling to understand how to use it and using it in the right manner”. This is indicative of an expectancy of being tenacious, as he explains: “the hard part is to push on and keep doing it”. Participants outlined the importance of a continuous application of approach for long-term benefits, as Lynda said: “I want to know that I’m doing the proper route rather than just fast tracking it and feeling great for that one day and not actually putting into practice.” These accounts evidence participants’ concern about the challenges of adhering to the protocol in therapy, instead of acting for more immediate relief from depression, in the knowledge that the benefits of this approach could be more gradual.

Irrespective of the psychological intervention received, participants expected their depression to be a part of their future experiences of themselves:

I guess depression and anxiety is an onward forever battle a bit like eating disorders or anorexia and things like that, you can get rid of but it's always gonna be in your mind, and it will always be a part of your life (Emma)

The comparison with eating disorders provides further evidence of the challenge anticipated in trying to resist the depressive condition. This account also highlights the antagonistic nature of participants' relationship with depression, and the expectation that although the symptoms might subside they would not be able to separate themselves from their depressive experiences. This provides further evidence of how the experience of depression may become infused with an individual's identity (Rhodes and Smith, 2012). Indeed, adapting self-identity is regarded as an essential task in any successful transition, or response to change (Kralik *et al.*, 2006). These accounts also suggests a narrative of 'I have to fight to get what I want'. Accordingly, depression was viewed as recurring and requiring continuous management:

You can fight depression all your life and be in and out of it all the time (Emma)

Allan anticipated that the severity of the challenge would necessitate a commensurate degree of effort: "the hardest things you have to work hardest at". Using his musical training as a frame of reference, he cites the importance of repeatedly practising an approach to improve his competence in managing depression: "practising as often as you can, it's a practical way of getting better". He foresaw this becoming more of a challenge as he improved: "the better you get the longer you have to practice and the more incremental it becomes, more pain equals less gain." This account highlights the issue that maintaining progress in and beyond therapy would be associated with fewer apparent rewards for the continuous effort, as compared with the extensive progress that could be experienced in therapy.

Discussion

This section presents an overview of the main findings reported above, about the expectations that these participants with depression had for therapy. It captures the difficulty they had in being confident that the help would be effective, the hope that therapy is a place to be open about their problems and create a chance to heal from the wounds of depression, and their conflicted attempts to understand how therapy might help them deal with depression. The implications for mental health services and counselling psychology are also discussed below, along with the limitations of this study and possible areas for further research.

Overview of the Main Findings

The findings presented describe how participants tried to understand the prospects for change in themselves and their depression. The first of three overarching themes, Therapy – a faint hope, brought together two themes which highlight the possibility for change from therapy on the one hand, and on the other hand, the challenge in believing there is a way forward when they seem to be the problem.

The first theme *Could therapy work? Hope versus hopelessness*, captured participants' sense of being trapped in (Emslie *et al.*, 2006; Midgley *et al.*, 2016; Rhodes & Smith, 2010), and of being concerned that they would not find a way of escaping, their depression (Alcalá *et al.*, 2012; Henkel *et al.*, 2002). Their hopelessness (Allen, 2007; Taylor and Loewenthal, 2001) sat alongside the fear that therapy would be a waste of time. This was juxtaposed with a sense of optimism that change could occur, as the step to come for therapy suggested, but this hope appeared fragile and ambivalent (Halgin *et al.*, 1987). Having very little idea of what therapy was (Midgley *et al.*, 2016; Watsford *et al.*, 2013) seemed to make it difficult for some participants to envisage how it would help them (Codony *et al.*, 2009; Elliot *et al.*, 2015).

The theme *Because I'm flawed*, captured how participants were concerned that the core aspects of their depression reflected flaws in themselves as individuals (Rhodes & Smith, 2010), resulting in a kind of helpless-dependence (Barnes & Mercer, 2004; Fennell & Cambell, 1984), and wanting to take everything that the therapist could give them. For some participants, their character flaws reflected deeply buried issues that were hitherto unknown suggesting therapy might have a role in excavating these. Participants spoke about their avoidant patterns of behaviour, which were intended to protect themselves from injuries to their self-esteem caused by failures, and which counter-productively

increased their sense of inadequacy through a loss of self-efficacy (Brown *et al.*, 2000). In addition to these self-defeating behaviours, participants despaired at how they sabotaged and were flagellating themselves, intensifying their self-loathing (Granek, 2006), and inflating doubts about therapy being helpful (Perry & Magnusson, 1988; Rutherford *et al.*, 2010). Some participants wanted to completely reject their own flawed ways of managing depression, accepting whatever the therapist might offer, this being perceived as their only chance of changing.

The second overarching theme, *Being helped to heal myself*, presented three themes which reflect participants' need to talk openly about their difficulties so they could equip themselves to work through them, in the context of societal expectations relating to control and responsibility, prior negative help-seeking experiences and stigma.

In the theme *Being open and accepted*, participants expectation of therapy being an explorative arena that would facilitate an open discussion of their problems (Midgley *et al.*, 2016; Watsford *et al.* 2013), was captured. Carrying the burden of responsibility for their depression (Barney *et al.*, 2009), difficulties describing their inner world (Emslie *et al.*, 2007), others' subjective responses (Williams & Healy, 2001) and concerns about being acceptable (Reeve, 2000), had made communication problematic. Therapy was therefore anticipated to be confessional in nature (Lewis, 2012), as well as emotionally cathartic. Stigma relating to their condition and the need for help (Taylor and Loewenthal, 2001), and negative media portrayals (Orchowski *et al.*, 2006; Tambling *et al.*, 2014), appeared to be internalised by participants (Barney *et al.*, 2009) who feared losing control (Griffiths *et al.*, 2006) and being repelled by others (Barney *et al.*, 2009). They consequently sought empathic and normalising responses from their therapist to help them feel comfortable with the task of being open (Clement *et al.*, 2015), in order to make sense of their experiences.

The theme *I want to better myself, but I can't do it alone* conveys how participants hoped to become self-healers, thereby developing an internal locus of control (Reynaert *et al.*, 1995). Reflecting their sense of responsibility for learning ways of managing their depression (Williamson, 2015), self-belief and self-acceptance were seen to be crucial to this process, as well as finding new ways of perceiving themselves (Bachelor, 2011; Midgley *et al.*, 2016). Many participants felt that something had been absent from their own attempts to remedy their depression and so they expected their therapist to be capable of leading and facilitating therapy (Watsford *et al.*, 2013), potentially in a non-collaborative fashion (Westra *et al.*, 2010), and provide guidance and information-sharing.

Participants expected that they would need to be amenable to their therapists' influence. These facets of participants' expectations potentially served to help them manage the responsibility for recovery and protect themselves against their helpers' negative attitudes (Pill *et al.*, 2001; Barney *et al.*, 2009).

The theme *Finding a good helping relationship* encapsulated the value placed on having a positive relationship to their recovery (Bachelor, 2013; Beattie *et al.*, 2009; Paulson-Karlsson & Nevonen, 2012; Woolfe, 2012). Difficulties disclosing (McNair *et al.*, 2002) and feelings of vulnerability were expected to be mediated by a therapist who they would bond with (Bachelor, 2013), and has professional boundaries (Emslie *et al.*, 2007). Additionally, the therapist was expected to help them feel at ease (Tambling *et al.*, 2014; Watsford *et al.*, 2013), and be non-judgemental (Clement *et al.*, 2015), caring and communicative. Participants expressed concerns relating to negative experiences of help-seeking (Beattie *et al.*, 2009), such as being misunderstood and ridiculed (Williams & Healy, 2001). The therapist was expected to be responsive and accommodating, and provide opportunities for collaboration (Midgley *et al.*, 2016). Therapy was therefore regarded as a joint venture in meaning-making (Anderson & Goolishian, 1992; Lewis, 2015).

The third overarching theme, *How will I deal with my depression?*, brought together two themes which explain how participants see therapy helping them.

The theme *Understanding how to get back on track* captures how participants sought to deal with their depression by restoring themselves to their former, pre-depression state (Midgely *et al.*, 2016). This was anticipated to happen by locating and understanding the origins of their depression, and by tracking factors believed to be associated with the onset of their low mood. Akin to pulling weeds up from the roots, this exploratory endeavour was seen to be essential in preventing the recurrence of patterns of being which had contributed to their condition. In this way, depression was understood by participants as being a loss of their "true" selves, and therapy would facilitate its recovery.

Finally, the theme *Whether to control or eliminate depression* provides a synopsis of how participants sought to address their problems in therapy. Many participants wanted to have conscious control of their thought processes, envisaging that vigilance to triggers and warning signs of low mood, and improved decision-making, would help them to react more purposefully, making their mood more manageable. This theme also captures participants' desire for non-talking interventions (Arch & Craske, 2008), and these were

mainly expressed as vague expectations of adopting new practical coping strategies (Watsford *et al.*, 2013). By contrast, some participants expressed a hope that therapy would eradicate or shut down the distressing experiences associated with their depression (Midgley *et al.*, 2016). Many participants posited an idea that they could become problem-free (Corrigan *et al.*, 2000; Crisp *et al.*, 2000; Jorm *et al.*, 1997), and hoped that therapy would be their magical solution, at the same time, acknowledging the potential fiction in this. Consistent with their existing experiences, participants more often envisaged that their recovery in therapy would be ongoing and effortful, requiring determination and persistence. They anticipated making incremental progress towards becoming more consistent in themselves; in other words, fulfilling the task of a transition to living with depression (Kralik *et al.*, 2006).

As these findings illustrate, the three overarching themes which describe how participants grapple with the question of whether they are helpable in therapy, are bound by a common thread comprised of the interlinking strands of identity, agency and responsibility: participants sought to understand who they were as people with depression, and who they could be; they strove to understand whether and how they could have control; they spoke about the way that feelings of responsibility were both important and hindering.

Implications for mental health services

A principal finding from this study was that clients approaching therapy may be doing so from a relatively uninformed position (Watsford and Rickwood, 2014). The provision of information could help people with depression understand what therapy is and how it could help (Constantino *et al.*, 2011; Watsford *et al.*, 2013). This study indicated that the need for information varied. Information that would be helpful to people considering therapy might include practical information such as the process of therapy, the length of sessions, how many sessions they will have, and potentially why the number of sessions is limited. These interventions may help to reduce pre-therapy attrition rates which are known to be higher for clients with depression (Issakidis & Andrews, 2004). In addition to written information, clients may benefit from information presented through other mediums. *Mind* and *My CAHMS choices*, for example, have produced online video resources for this purpose.

There are a number of recommendations that could be made given how important participants expected the relationship to their therapists to be. Firstly, arranging the initial

appointment through telephone contact might help to establish a rapport and make clients feel more comfortable when seeing their therapist for the first time. The possibility of working with a therapist with whom they do not bond may cause anxiety and increase further doubt about receiving the help they want in therapy. Pre-therapy information could address this by clarifying what clients could do in these circumstances, helping to build their confidence that they will get helped.

This study highlights the concern that people with depression continue to be stigmatised in ways that potentially affect their use of mental health services. Arguably, interventions aimed at changing lay attitudes towards mental health issues, such as the Royal College of Psychiatry's *Changing Minds: Every Family in the Land* (Crisp, 2000), have not been wholly successful. Given how depression remains a hidden illness to many (Elliot *et al.*, 2015), further efforts are needed to normalise the difficulties that arise from the condition, and the findings suggests two possibilities. Firstly, normalising depression as a health issue may help to reduce stigmatisation (Barney *et al.*, 2009). This approach would have some congruence with the reality that most mental health services operate from and are accessed via physical health services. For some (Mitchell, 1975; Williams and Neighbours, 2006), this approach unhelpfully frames what could be regarded as a problem of life as having biological properties, and conceptualises people with depression as defective, suggesting a need for sensitivity in how this is applied. A more radical approach would involve services doing more to overcome society's fallacy that we are all functioning perfectly, by highlighting the need for support with life struggles that we all to a lesser or greater extent endure (see Pill *et al.*, 2001). This study also indicates that stigma-reduction initiatives should target attributions of blame (Barney *et al.*, 2009), and based on the concerns reported above, focus particularly on the dimensions of responsibility, repulsion, and sense of threat. This research confirms a need to address stereotypes, such as being weak or having madness, which increase social issues such as marginalisation and isolation, and feelings of shame (see Clement *et al.*, 2015). Previous movements have highlighted a need for more proactive approaches if people are going to feel good about themselves in the communities that they live in (Osburn, 1998; Richards *et al.* 2003). Participants' reports indicate that improving people's awareness of online forums which facilitate contact with peers may improve their opportunities for normalising narratives and experiences.

Implications for counselling psychology and practitioners

Treatment expectancy has been called the “ignored common factor,” (Weinberger & Eig, 1999), and it would seem prudent to view expectancy as an active ingredient in the process and outcome of therapy (Constantino *et al.*, 2005; Glass *et al.*, 2001; Greenberg *et al.*, 2006). As counselling psychologists working relationally (Kahn, 2005), we are obligated to consider factors outside of diagnostically driven models of intervention which potentially influence the therapeutic encounter (Baker & Subich, 2008). Importantly, expectations are adaptable and could be the target of help-seeking interventions (Dew & Bickman, 2005). The vague notions of what therapy is carried by prospective clients further support existing recommendations around the need to provide a treatment rationale (Lorber *et al.*, 2007; Van Audenhove & Vertommen, 2000). Fennell and Teasdale (1987) advocate giving information to improve clients’ acceptance of the rationale, and this has been shown to predict treatment outcome in studies of CBT for depression (Addis & Jacobson, 2000). There are numerous examples online and the Northumberland Self Help guides are an excellent example of such a resource.

A cognitive approach, such as providing information to evidence the efficacy of an intervention, is likely to improve its credibility. However research by Devilly and Borkovec (2000) suggests that therapists trying to facilitate a placebo effect should be aware that expectancy has been demonstrated to be affective in dimension. This is particularly significant in the case of people with depression, suggesting efforts need to be taken to overturn feelings of hopelessness and helplessness and generate feelings of hope (Beck *et al.*, 1993). This research suggests that depression leaves its own fingerprint on clients’ expectations for therapy (Tsai *et al.*, 2014), bringing a unique set of challenges to therapists trying to positively orientate them to the intervention, to accrue the most benefit possible. Research indicates that modifying the language and content of treatment rationales to suit individual clients (Kazdin & Krouse, 1983), and employing case exemplars (as evidenced in Tsai *et al.*, 2014) can effectively improve expectations in depressed clients. In reality, the latter may be more achievable with certain modes of therapy, such as CBT, where the models mean that interventions are intrinsically more predictable (and the University of East Anglia website has useful resources for this purpose).

It is widely regarded as the therapists’ responsibility to explore the clients’ expectations at the outset and negotiate goals, as befits standard practise of contracting. This is understood to benefit the therapeutic relationship (Rutherford *et al.*, 2010). The relevance of expectations to therapeutic outcomes (Lambert, 1992) also speaks to the

importance of client autonomy (BACP, 2002), which is itself conducive to good mental health (Rogers, 2012). As practitioners, there is a need for awareness around the parallel processes relating to our clients' sense of agency (Rennie, 1994), which may pull us in the direction of forming assumptions about what is best *for them*, or making unilateral decisions. This study demonstrates how in practise it may be difficult to elicit specific expectations, or concrete goals, which is problematic since expectancy-response is specific to an individuals' expectations (Lorber *et al.*, 2007). This study suggests that Counselling Psychologists would benefit from thinking of expectations in broader terms than goals, indeed good practise guidance directs us to consider, 'all the contexts that might affect a clients' experience and incorporate it into the assessment process, formulation and planned evaluation' (BPS, 2005, p.7). For first-time clients, these findings suggest it may be helpful to ask clients whether they have any concrete experiences of help-seeking and what implications these have for their expectations. As McLeod (2012) says, clients are likely to know what could be helpful from their prior experiences of trying different approaches. Additionally, it may be easier to discover expectancies via discrepancies that can be identified after the intervention has been explained and asking clients how this fits with their own expectations for what would happen.

Moreover, it seems useful to consider the discussion of expectations as an iterative process for a number of reasons: as the treatment progresses, how the client experiences both the intervention and the therapist will influence their ongoing expectations (Rutherford *et al.*, 2010); more severely depressed clients will have difficulty arousing positive expectations before therapy (Shapiro & Shapiro, 1997) but may be more receptive to attempts to modulate these once the intervention has begun. (There might also be an argument for the use of medication to target symptom reduction before engaging with therapy here (Murakami, 2011)). Nevertheless, creating opportunities for feedback, especially in the case of less-well engaged clients may reduce the risk of treatment failure (Lutz *et al.*, 2015).

The problem of stigmatisation faced by people with depression suggests that people's experiences are still not being heard and accepted as valid, which presents an issue of concern to us given our commitment to social justice (BPS, 2005). It would appear that people with depression continue to feel unfairly marginalised, exacerbating their sense of isolation and alienation (Midgley *et al.*, 2015). This calls into question the impact of existing policies aimed at reducing these issues. In terms of the therapeutic encounter, a number of interventions may be helpful. Many people with depression have had

significant and affecting experiences of not being heard or of being dismissed. Avoiding being too quick to provide therapeutic explanations and taking the time to understand their frame of reference may help to build a therapeutic alliance. However, it is acknowledged that the scope for achieving this in practise may be limited as many mental health services offer a brief therapy model or provide psycho-education as its front-line intervention, or because of other therapeutic priorities (see Lewis, 2015). Clients with depression may present with strong feelings of responsibility for their condition, and in addition to being self-critical they may anticipate negative reactions from their therapist, and behave according to this expectation, such as giving feedback selectively. This suggests a role for therapists identifying poor self-compassion, and encouraging a self-compassionate perspective where necessary (Gilbert, 2009).

The findings indicate that having depression is an identity-changing condition and therapists have a role in helping them manage this transition (Kralik *et al.*, 2006). Expectations of eliminating their depression and returning to their old self help people see their condition as transient, thereby offering hope (Midgley *et al.*, 2016), whilst impeding the challenge of managing the transition in identity (Kernberg, 2009). This would suggest that therapists have a delicate task of orienting clients to perceive themselves as someone who has lived with depression, and who may continue to live with it in the future, to some extent. This is a particularly challenging task since this study illustrates how identity may be intertwined with adequacy concerns and issues of responsibility. Ridge & Ziebland (2006) describe recovery in terms of coming to view depression as “part of the experience of self but not the same thing as the self” (p.1045). The authors note that that the experience of depression could be “rewritten” as part of developing a different relationship to it.

Limitations

Caution should be applied in considering how the findings reported in this study apply. As with most qualitative methodologies (Braun and Clark, 2013), this research did not propose to deliver generalisable findings. Positively, this qualitative research compliments more generalisable (i.e. quantitative) approaches by providing an opportunity to examine an under-researched and ambiguous topic in greater depth (Barker *et al.*, 2002; Rhodes & Smith, 2010; Smith, 1995), and by counterbalancing its positivist assumptions (McLeod, 2001).

To conduct research in a way that was morally and ethically acceptable only non-suicidal participants who were either mildly or moderately depressed were recruited, with the concern that the interview questions may have caused more severely depressed people undue distress. It is possible that significantly different expectations would have been captured, as is suggested by existing research indicating that severely depressed clients have more negative expectations, and are less amenable to pre-therapy attempts to change these (Tsai *et al.*, 2014).

The fact that participants knew that the researcher was a therapist who worked at the services they would receive help from may have introduced some bias in participants' answers (Tambling *et al.*, 2014). It is possible that the researcher's status elicited different responses, potentially out of expectation of what could happen with the information. One participant was explicit about his intention to take part to try to improve services, for example. The aforementioned difficulties in recruitment for this study may suggest a potentially connected limitation. Those who did not wish to take part could have had relevant expectations for therapy which they were not content to disclose to a therapist working in the service.

Another limitation of this study is that the recruited individuals had either initiated a referral for a talking therapy themselves, or acted in accordance with their GPs referral. There is then an omission around the expectations for therapy in those who could benefit from therapy to help them with depression but have not yet pursued this option. This is significant given the reluctance towards help-seeking in people with depression (Roness *et al.*, 2005; Taylor and Loewenthal, 2001), and because of the potential implications this could have for orientating mental health services more effectively to provide earlier treatment (Montano, 1994).

There is a need to acknowledge that expectations are not static (Tsai *et al.*, 2014), and this research simply presents a snapshot of these participants' expectations at the moment that their interviews were conducted, and in that setting. The research offered tentative evidence of how expectations could differ in time. For example, the participant whose therapy was very imminent expressed concern about the absence of information about therapy and how it could help more acutely than other participants. Certainly, while pre-therapy expectations are important to early engagement in therapy (Haas *et al.*, 2002; Tsai *et al.*, 2014), a client's early experiences in therapy are predictive of longer-term developments in their therapy. Existing research (Lewis, 2015) suggests that those who presented with vague pre-therapy notions had an improved sense of what they did and

did not want once they had started therapy. Unlike this and some other studies (such as Ekberg *et al.*, 2014), this investigation did not seek to compare the relationship between expectations and experiences in therapy, so the actual impact of these participants' expectations remains unknown.

This research has been concerned with understanding more about expectations for therapy for depression, and is further limited in its focus on clients' expectations, which could be argued to be only a part of the expectancy picture. Some research has revealed that therapists' expectations contribute to therapeutic outcomes too (Nienhuis *et al.*, 2016; Roos & Werbart, 2013), though none specifically relate to seeing clients with depression.

Finally, researcher bias is potentially problematic in all forms of research and qualitative forms of enquiry are particularly susceptible to this, perhaps necessarily so. Clark and Braun (2012) expound the importance of using language that reflects the subjective nature of the analysis, and that in rejecting the positivist position, acknowledging that codes and themes are created rather than discovered. Biases and expectations affecting the procedures undertaken in the course of this research, which have arisen from this researcher's personal experiences, are captured in the Methodology Section, and are reflected upon further below.

Future research

Although one participant reported that he needed to hold positive expectations for what the therapist would be trying to achieve with him, participants rarely reflected on the importance of having expectations in their interviews. At the time of writing, there is no known research which has explicitly set out to explore clients' beliefs about the role of expectancy. This research indicates that given the challenge of generating positive expectations for individuals with depression, understanding more about their perspective will advance our knowledge about how to tailor pre-therapy information, and the possible need to develop specific interventions in terms of their socialisation.

The analysis reported above presented an apparent contradiction in wanting robust facilitation from the therapist in the face of rejecting their counterproductive coping strategies (Goldfarb, 2002), and having expectations of having influence and being involved in the decision-making. Whether these expectations for a collaborative experience co-exist with expectations for an active and directive therapist is not well understood. This research suggests that the two are not mutually exclusive which allows

us to posit that they exist on a continuum. It would also be helpful to understand whether clients would benefit from matching the extent to which they have an internal or external health locus of control to how directive (i.e. instructive vs collaborative) the therapist is, or even to the therapy orientation (e.g. CBT vs counselling).

Difficulties in recruitment may be an important area for further research, given that there may be some parallels with the reported reluctance in people with depression to come for therapy. The findings reported here indicate that factors such as not knowing what therapy is, feelings of failure and inadequacy which are exacerbated by a sense of responsibility for controlling their mood, and the fear of being stigmatised, may be contributory. Future research would help ascertain whether fears of being exposed in this way affect willingness to participate in research.

There is a need for expectancy research to investigate differences relating to diverse groups in society. This research captured how only females disclosed expectations of being able to express themselves emotionally in therapy, potentially reflecting traditional gender norms (Strazdins & Broom, 2004), and it is a reasonable supposition that there may be other differences identified (Emslie *et al.*, 2007). Expectancy research could also seek to explore how people belonging to ethnic minority groups think in anticipation of therapy, particularly since talking therapies may be more or less congruent with a person's culture (Murkami, 2011).

Reflexivity on the process of research

The findings of the study also have implications for me as a counselling psychology trainee. From a scientist-practitioner perspective, this research has reaffirmed the importance of the qualitative endeavour. It helps us to understand the intricacy of people's experiences, and here, it has helped me to explore the nuances of people's expectations. I accept that my motivation to adopt this approach partly reflects a reaction of frustration to the number of contradictory quantitative studies in this field of study (Glass *et al.*, 2001; Greenberg *et al.*, 2006). Nevertheless, as my first foray into this research methodology, it has shown me how aligned it is to the values of Counselling Psychology (Rennie, 1994). They seek to understand individual people from a position of subjectivity (Woolfe, 2012) and consider how they may be shaped by all of their contexts (BPS, 2005), both past and present. It is believed that these factors will affect the therapeutic alliance, another context in which change may happen (Bachelor, 2011).

As prospective clients, these participants' accounts highlight the importance of the therapeutic relationship in offering them an opportunity to join with another to understand if and how their expectations for recovery from depression are plausible. It reminds me that clients value therapy as a place of meaning-making (Lewis, 2015) where their problems can be made sense of *en route* to healing themselves, and that this remains an important part of my therapeutic craft. Engaging with this research has helped me to develop an awareness that this process is present in all aspects of my participation with a client, from contracting onwards, meaning they are all "intervention". It helps me to understand more concretely that in some instances of having a poor therapeutic alliance, I had incompletely met this task, for example, by understanding the clients' goals well but less clearly their process or role expectations.

I have become aware that in depression, a person's identity could be at the heart of their concerns (Berzonsky and Ferrari, 1996), and there may an implicit expectation of therapy to help them to answer the question "who am I?", irrespective of the specific goals and tasks of therapy. The research brings back echoes of my early learnings in sociology and psychology, such as Cooley's looking glass self (Tice, 1992), in my thinking about how society's norms continue to influence the way that individuals experience themselves when they have mental health concerns. This points to the evolving and iterative nature of my learning (Kolb, 2014), as I try to improve my competence and develop as a counselling psychologist practitioner (BPS, 2005).

For me, this study underlines the significant investment clients have made even prior to coming for therapy (Manthei, 2006), and alludes to the considerable risk that many will feel in taking this step. Many clients arrive from contexts which have made it hard to develop an attitude of acceptance in relation to their areas of difficulty, including their mental health concerns. Revisiting my early training, I think that offering a nuanced caring approach (McLeod, 2012) and including opportunities for my clients to develop self-compassion (Gilbert, 2009) may provide some much needed relief from negative self-judgement.

This research also gives me cause for thought about how I use my power as a therapist. Historically I have tended to regard being directive as a negative use of that power, given the privileged position that we occupy in that role (Muran & Barber, 2011), assuming that this would be experienced as imposing. The participants' accounts indicate that having a directive-but-listening therapist in the earlier stages of the work may be in keeping with some clients' support requirements. This accords with Vygotsky's notion of scaffolding

(see Kozulin, 2004), with collaborative discussions influencing the direction and level of this support. Here concepts from the psychology of education and therapy – both interests of mine – intertwine and this theme was also evident in these participants' accounts of their expectations for therapy. Therapy involves a programme of learning about the self, and becoming self-sufficient, consistent with Bandura's notions of self-efficacy and self-regulation (Hardy, 2006; Williamson, 2015). The research speaks of the benefit of the therapist as a good role model (Vespia, 2006) to this effect. These ideas certainly contribute to my identity as a counselling psychologist. Finally, the research shows me that client agency and involvement are fundamental to the basis of therapy (Knox & Cooper, 2015), and it expands the ways I might think about myself as a responsive therapist. Finally, it leads me to believe that a collaborative approach in respect of clients' expectations may point me in the direction of a more pluralistic approach (Cooper & McLeod, 2010) in seeking to leave clients with a good counselling experience (Yalom, 1989).

Conclusion

This study sought to understand how people's experiences of help-seeking and depression influence their expectations of therapy, from a client perspective. The findings in this study confirm that having depression has an impact on expectations, with implications for the prospect for eliciting the placebo. They capture clients' difficulties believing that they might change or recover from depression. Specifically, therapy is an unfamiliar concept for many of those looking for help, which has implications for how they can see it supporting them. Participants' responses highlight the impact of closed and unforgiving attitudes towards depression, particularly in terms of a struggle for control, with consequences for their identity. Clients hope that therapy will meet their need for autonomy by furnishing them with the necessary tools to achieve this, with implications for mental health provision and for future research. It is hoped that this research further demonstrates the value in employing a phenomenological perspective to provide a richer, more detailed understanding of people's experiences of depression (Rhodes and Smith, 2010), and how they expect these experiences to change and improve through psychological therapy.

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Journal Article

Can I be helped? The prospects for change in me and my depression: a thematic analysis of pre-therapy expectations.

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Abstract

While clients' expectations are understood to contribute significantly to outcomes in therapy, attempts to understand this contribution have been confusing, and there is a paucity of research on the subject for adults with depression seeking therapy. This is significant given that people with depression are less likely to seek help and have higher rates of pre-therapy attrition compared to people with other presentations. Moreover expectations for therapy are likely to play a role in clients' early engagement in therapy, which is seen to be a critical phase for improvement. This research provides a qualitative account of the pre-therapy expectations of twelve adults who were on waiting lists to receive psychological therapy for depression. A thematic analysis was carried out on the data obtained from semi-structured interviews which explored participants' experiences of depression and help-seeking, and their expectations for therapy. The first overarching theme, Therapy – A faint hope, explored the difficulty participants had with envisaging how, and having conviction that, therapy would help them. The overarching theme, Help to heal me, describes how participants sought a sanctuary of acceptance in order to talk about and ultimately self-manage their problems. The final overarching theme, How to deal with my depression, highlights the way participants conceptualised solutions to their depression. The study has implications for how mental health services and practitioners engage with people with depression.

Keywords: therapy expectations, depression, help-seeking, qualitative, common factors

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Introduction

Help-seeking in people with mental health concerns is low, and more so for individuals with depression who may be half as likely as people with anxiety to obtain psychological help (Roness, Mykletun and Dahl, 2005). The authors suggest that the characteristic symptoms of depression, such as passivity and pessimism, may be a factor. Depression can include low mood, loss of interest, and reduced energy and activity levels (WHO, 2007), with a cognitive bias towards more negative patterns of thought (Beck, Steer, Beck & Newman, 1993). Other research indicates that it may be attributions of blame to the individuals themselves (Barney, Griffiths, Christensen & Jorm, 2009) that distanced them from help-seeking.

Help-seeking may therefore be affected by negative attitudes that individuals hold towards toward their own mental health (Pill, Prior & Wood, 2001), potentially reflecting stigmatising views in the general population (Barney Griffiths, Christensen & Jorm, 2009) and from healthcare professionals (McNair, Highet, Hickie & Davenport, 2002). According to Taylor and Loewenthal (2001), stigmatising views make it taboo, and cause people to believe that nothing will help, that they should not discuss these issues, and that they are a burden. Strikingly, Johnson, Oliffe, Kelly, Galdas and Ogrodniczuk (2012) found there was little discourse about what people with emotional distress wanted to happen, and so participants were uncertain in anticipation of their initial discussions with healthcare professionals. It follows that that these factors could produce fairly negative expectations for therapy.

Research into the effect of people's expectations in treatment originates from studies into the efficacy of psycho-pharmacological products as solutions for mental health conditions, with the finding of the so called "placebo effect" (Beecher, 1955). In antidepressant trials, more positive expectations for treatment were related to better clinical improvements (Moses, Leuchter, Cook & Abrams, 2007; Rutherford, Wager and Rose, 2010). They could therefore conclude that interventions could be oriented to benefit from this by working with individuals expectations for treatment gain.

A definition of expectation in the context of an individual facing therapy is provided by Nock and Kazdin (2001): "anticipatory beliefs that clients bring to treatment and can encompass beliefs about the procedures, outcomes, therapists, or any other facet of the intervention and its delivery" (p. 155).

In his “common factors” model of therapy, Lambert (1992) asserted that clients’ expectations are a significant factor in therapeutic outcome, regardless of therapeutic modality. Much of the expectancy research in therapy has aimed to evaluate the quantitative evidence for improved therapeutic outcomes, with inconclusive results (see reviews by Glass, Arnkoff & Shapiro, 2001 and Constantino, Arnow, Blasey & Agras, 2005). Inconsistent results were also found for a role for the disconfirmation of role expectations in improved outcomes (Duckro, Beal & George, 1979). By contrast, research found expectations were positively correlated with working alliance, which itself has been found to be associated with better outcomes (Dew and Bickman, 2005; Patterson, Uhlin & Anderson, 2008).`

Some of the limitations of the existing quantitative expectancy research concern study design: studies used poorly operationalized variables (Duckro, Beal and George, 1979); different clients’ expectations have not always been measured at the same point in therapy (Glass *et al.*, 2001); the measurement tools used had often not been psychometrically validated (Dew & Bickman, 2005). Ultimately, the research has provided a limited understanding of why expectations might affect therapeutic outcome (Glass *et al.*, 2001). Quantitative studies are typically reliant on self-reports using rating scales, which only allow participants to respond within predefined categories (McLeod, 2001). Arguably, questionnaires have a limited focus and do not capture the client’s perspective well (Manthei, 2006). By studying client experiences through qualitative interviews the researcher can learn what clients expect in therapy, this perspective being delivered in their own words. There are very few studies that enable us to get a qualitative understanding of clients’ expectations of therapy.

In a case study that juxtaposed others’ views with the clients own expectations, it was found that attending therapy brought an apparent dilemma between having others’ approval and meeting a perceived need for themselves, leading to feelings of self-doubt and inadequacy (Taylor and Loewenthal, 2001). Maier and Straub (2011) interviewed migrants who had suffered trauma about their treatment expectations. They could not account for themselves using their usual socio-cultural frames of reference, and consequently, their treatment was perceived as an opportunity to attend to this crisis of identity by redefining themselves. Westra and colleagues (2010) identified negative process expectations for therapy, such as: it will not be collaborative, there will be an absence of opportunities for control, and the degree of discomfort will high. Research by Lewis (2015) underlined the importance of clients’ experience of contracting, directiveness, engagement and alliance in relation to their initial expectations. It also highlighted a need for there to be more explicit awareness of power in the therapeutic alliance.

In research that specifically examined depressed young clients' expectations for individual therapy (Midgley, Holmes, Parkinson, Stapley, Eatough & Target, 2016), talking was intuitively seen as means by which they would be helped in therapy. They reported that participants had difficulty generating expectations for therapy. A significant limitation of the qualitative studies captured above, in the areas of help-seeking and expectancy, is that clients had already begun or completed their course of therapy when their pre-therapy expectations were sought (Dew & Bickman, 2005), and studies did not exclude those with previous experiences of being a client.

In an attempt to redress this issue, this study sought to investigate expectations for therapy in adults with depression, who have not yet received therapy, with the following rationale. The way that depression is understood as a condition suggests that it may present a specific type challenge with regard to managing expectations (Blackburn & Twaddle, 2011). Pre-therapy clients provide practitioners with perceptions that are raw and unencumbered by the language and experience of therapy (McLeod, 1990). For the purpose of gaining an understanding of these expectations to any degree of depth, it would seem to be difficult, and counterproductive even, to try to untangle them from the individuals' perception of their difficulties, and any help-seeking attempts that they have already made to remedy these (Tsai, Ogrodniczuk, Sochting & Mirmiran, 2014). It is likely that some preconceptions are likely to also be enmeshed with ideas about their condition and help-seeking that are socio-cultural in origin.

Method

Participants

Participants were a non-probabilistic, purposive sample of 8 males and four females, aged between 18 and 65 (mean age 40) waiting for individual help for their depression. The Exclusion criteria were having previously been involved in therapy as a client, therapist or student, those reporting a need to be supported to communicate in English, those with severe depression or suicidal concerns.

The decision to accept only participants who could adequately express themselves in English was based on the need to obtain first-hand accounts of participants' experiences, because of the importance of the meanings that they ascribe to those events. The non-inclusion of severely depressed individuals and those assessed to present a risk to themselves was based on the ethical consideration of nonmaleficence (British Psychological Society, 2011). Participants' scores on the Beck Depression Inventory II (BDI-II) ranged from 14 to 28 (i.e. mild to moderate; mean score= 20).

Recruitment took place in two locations, a third-sector counselling organisation in south wales, and in an organisation that was involved in the delivery of primary care mental health services, subsequent to obtaining approval from NHS ethics board and a clinical commissioning group.

Data collection

Data was obtained from face-to-face semi-structured interviews, which offered flexibility needed to explore how participants made sense of what they anticipated in therapy, thereby revealing their 'psychological reality' (p.10, Smith, 1995). Questions examined what participants expected of therapy, in the context of their experiences in the course of making the decision to undertake this course of action, and their perception of their depression and their previous help-seeking endeavours.

The digitally audio-recorded semi-structured interviews, of a duration between 60 minutes and 110 minutes (mean = 88 minutes). Audio-recorded interviews were transcribed verbatim according to basic orthographic conventions (Jenks, 2011). This formed the data corpus which were analysed using the procedure described below. Participants were given an opportunity to amend or add to their transcripts.

Analysis

A Thematic Analysis (TA) was performed to organise and analyse the qualitative data according to the six-phase guidelines outlined by Braun and Clark (2006), culminating in the formation of a thematic map. The data was processed on the basis of an a priori assumption that there are areas of shared meaning about the participants' experience of becoming and ultimately of seeking professional help (Braun & Clark, 2012). The investigative stance was inductive, that is, the data was scrutinised for meaning using a bottom-up approach, allowing themes to be formed from semantic patterns within the data. The analysis placed importance on giving a voice to participants' experiences and understandings, rather than being critically interpretative. Adopting a contextualist epistemological position, this TA provided scope for this research to acknowledge the social context in which participants' help-seeking expectations were formed (Braun & Clark, 2013).

Results

The following section outlines three overarching themes which were generated in the thematic analysis, which draw on a central idea that participants sought to understand the prospects change in themselves and their depression.

Overarching theme 1: Therapy – a faint hope for me

The first of three overarching themes, Therapy – a faint hope, brought together two themes which concern the possibility for change from therapy on the one hand, and the challenge in trying to believe there is a way forward when they perceive themselves to be the problem.

Uh, I'm all for it [therapy] but at this point I've not being able to get through this, it just feels like a dead end when it comes to these issues. So if that's starts to break through that brick wall (Allan)

The first theme Could therapy work? Hope vs hopelessness, captured how participants expressed their feelings of hope and hopelessness for therapy. Participants described a sense of being sense of being trapped in (Rhodes & Smith, 2010), and of being concerned that they would not find a way of escaping, their depression (Rhodes & Smith, 2010; Midgley, Parkinson, Holmes, Stapley, Eatough, 2015). Emma articulated the difficulty of envisaging herself being outside of it:

It doesn't take a lot then to tip me back if I get myself better, it just takes a very little thing now and then I'm back in the loop, when I'm really down and everything goes tits up, then it's really hard to get out of once you're in like the circle of things" (Emma).

This echoed others accounts about how effortful it was to improve their wellbeing, and by contrast, how effortlessly their mood deteriorated. These experiences fuelled feelings of hopelessness, for James, about being able to learn and use ways of coping in therapy (Taylor and Loewenthal, 2001; Allen, 2007): "what do I do then that will uh make me feel better if you try a number of things and it's just not working, you kind of lose a bit of hope". These accounts support literature indicating that clients with hopelessness had reduced expectations of improvement (Nock & Kazdin, 2001; Goldfarb, 2002).

Participants also reported more optimistic expectations for therapy, such as how therapy presented them with opportunities to benefit, and ways of seeing themselves being successful in therapy (Tsai *et al.*, 2014): "I'd like to think it's achievable. I want it to be achievable" (Adam).

Such hopes appeared fragile and ambivalent (Halgin, Weaver, Edell & Spencer, 1987). James expressed concerns about therapy not living up to expectation: "Is it going to provide any benefits or is it just going to take up my time." The lack of a credible rationale was contributory (Horvath, 1990; Tsai *et al.*, 2014): "If you like you can go for this thing we'd recommend, it will probably help you change the way you think, and I just said, 'oh okay, big deal'." Having very little idea of what therapy was (Watsford, Rickwood & Vanags, 2013; Midgley *et al.*, 2016) seemed to make it difficult for some participants to envisage how it would help them (Codony,

Alonso, Almansa, Bernert, de Girolamo, de Graaf & Kessler, 2009; Elliot, Westmacott, Hunsley, Rumstein-McKean & Best, 2015), as articulated by Lynda:

What's going to happen, what are we going to talk about, um, that's really what's on my mind at the moment, not knowing what to expect, yeah.

Significantly, none of the participants reported receiving information about what therapy is. Participants' accounts portrayed therapy as hidden (Elliot *et al.*, 2015).

The theme I'm flawed, captured how participants were concerned that the core aspects of their depression reflected flaws in themselves as individuals (Rhodes & Smith, 2010). For Allan, his character flaws reflected deeply buried issues that were hitherto unknown suggesting therapy might have a role in excavating these:

Therapy will jog my emotional memory into remembering some things which are probably tucked away for a good reason

The perceived seriousness of the nature of these issue was reflected in a desire to purge them from their minds. Allan conceived of therapy as needing to resolve a conflict between the known and unknown parts of the self, saying he would, "have it out with myself really."

Participants spoke about their avoidant patterns of behaviour which were intended to protect themselves from injury to their self-esteem that might occur from failure: "the bad will still be the pride" (Lynda). This counter-productively increased their sense of inadequacy through a loss of self-efficacy (Brown, Schulberg & Prigrson, 2000): "when I'm depressed it's impossible. There is no goal, the goal is not possible." (John).

In addition to these self-defeating behaviours, Michael despaired at how he self-sabotaged and was flagellating himself, intensifying his self-loathing (Granek, 2006):

It's coming from yourself and you know yourself better than anybody really, how you feel inside, and your own deep thoughts and dark places, and so forth, and it plays on those (Michael)

For Simon, this inflated doubts about therapy being helpful (Rutherford, Wager & Roose, 2010) since it led to an avoidance of thoughts relating to his problems: "they feel that if they analyse themselves too much they might find themselves wrong". In keeping with the concept of having depression about depression, which tends to see depression as being caused by character flaws and consequently not being malleable to treatment (Fennell & Cambell, 1984), this resulting in a kind of helpless-dependence (Barnes & Mercer, 2004). Michael wanted to completely reject his own flawed ways of managing depression and accepting whatever the therapist might offer: "as

opposed to um trying to adapt it to your own way of thinking, cos um, quite clearly my own way of thinking isn't a 100 percent."

Overarching theme 2: Being helped to heal myself

The second overarching theme, Being helped to heal myself, presented three themes which reflect participants' need to talk openly about their difficulties and equip themselves to work through depression, in the context of societal expectations relating to control and responsibility, prior negative help-seeking experiences and stigma.

That would be good if you come away with a feeling that okay I'm not perfect, nothing is perfect, I'm still doing things wrong but I can accept that I'm doing things wrong and before you get to the over the edge you can step in there and maybe put them right (Lisa)

In the theme Being open and accepted, participants expectation of therapy being an explorative arena that would facilitate an open discussion of their problems (Watsford *et al.*, 2013; Midgley *et al.*, 2016), was captured. Participants, like Lisa, had an expectation of being able to discuss everything, including those less pleasing aspects of their experiences: "I think they will expect me to say it all, warts and all." For James, that openness would have enabled him to receive the most appropriate help from the therapist:

It's the same when you go and see a doctor about anything you want to be honest about what's happening and then they can get the full picture and say, "ah right, this is what you definitely need"

Participants spoke about their reluctance to talk about their problems. Reflecting difficulties describing his inner world (Emslie, Ridge, Ziebland, & Hunt, 2007), Adam said: "sometimes you don't know what to say or how to get something out." Mark thought that what he said would be perceived to be unacceptable (Reeve, 2000): "I think I would feel some of the things I think is wrong." Potentially being connected to the way attributions of responsibility are made for managing their depression (Barney *et al.*, 2009), therapy could be expected to be confessional in nature (Lewis, 2012): "at least I would have spat it all out. Got every single thing out" (Lisa).

Michael, expressing uncertainty about the limits of his own behaviour with depression, said: "You could turn." Such accounts suggest that stigma relating to their condition and the need for help (Taylor and Loewenthal, 2001), were internalised by participants, who feared losing control (Griffiths, Nakane, Christensen, Yoshioka, Jorm & Nakane, 2006) and being repelled by others (Barney *et al.*, 2009). James related his need for therapy to negative media portrayals (Orchowski, Spickard & McNamara, 2006; Tambling, Wong & Anderson, 2014): "you can think

about like crazy people, y'know recreate the picture like in the films." In these participants' accounts, having depression was viewed as inferring weakness or poor coping (Williams & Healy, 2001), abnormality or inadequacy (Scattolon, 2003).

Consequently participants sought empathic and normalising responses from their therapist to help them feel comfortable with the task of being open and making sense of their experiences, as James said:

Maybe they cannot take away the feelings but they can be there so I find comfort in knowing that, y'know someone is with me, if you see what I mean (James)

This highlights the positive emotional impact of receiving empathy, which fostered an atmosphere of acceptance (Clement, Schauman, Graham, Maggioni, Evans-Lacko, Bezborodovs, ... & Thornicroft, 2015).

The theme I want to better myself, but I can't do it alone portrays participants' hopes of becoming self-healers, thereby developing an internal locus of control (Reynaert, Janne, Vause, Zdanowicz & Lejeune, 1995), as Michael stated: "I think they'll be trying to get you to manage yourself and just helping you to do that". Lynda explained this in terms of needing to be responsible for her own wellbeing (Williamson, 2015), the limited availability of support: "people can't be with you all of the time, you are your own first-aider as it were".

Emma envisaged that the therapist would be actively seeking to nurture their feelings of resilience, as part of helping clients to become self-healers: "to feed that strength then across to the other side so that they could manage themselves in the same way". Lisa explained that having learned to understand her behaviour, around the events related to her depression, there would be more acceptance: "that I can understand why I did what I did, and you can accept that, and you can live with yourself." Self-belief and self-acceptance were therefore seen to be crucial to self-healing, as well as finding new ways of perceiving themselves (Bachelor, 2011; Midgley *et al.*, 2016):

If it starts that conversation and then it changes that shape of the dialogue which you have for yourself, then you can start I guess experimenting with perceiving yourself in a slightly different light (Allan)

Like other participants, John expressed concern that they had overlooked or had not yet discovered a key intervention that would help them to make the progress they sought: "maybe I'm missing a trick." He expected his therapist to be capable of providing guidance (Watsford *et al.*, 2013): "Try and guide the sort of train of thought down the road they probably think that

you really need to explore.” Lisa hoped more for leadership of a non-collaborative fashion (Westra *et al.*, 2010): “I am looking for somebody that’s going to tell me, look, this is what you need to do.” Simon’s account revealed an expectation that a distinct task of therapy was to educate and advise him, with the therapist being an expert in field: “it’s just simply I need more information and here’s another place of getting it” (Simon).

Participants expected that they would need to show commitment and be amenable to the therapists’ influence, as James indicated: “they might say well how come you sought out this treatment if you’re really not willing to engage with it”. These facets of participants’ expectations potentially served to help them manage the responsibility for recovery and protect themselves against their helpers’ potentially negative attitudes (Pill, Prior & Wood, 2001; Barney *et al.*, 2009).

In Finding a good helping relationship, this theme encapsulates the value of having a positive relationship, to participants, in their recovery (Paulson-Karlsson & Nevenon, 2012; Bachelor, 2013). Adam was concerned about disclosing (McNair *et al.*, 2002): “Will I be able to open up to her? What will she be like?” Simon spoke of his concerns about managing potential feelings of vulnerability: “there’s the risk that people might feel vulnerable”.

Such issues were expected to be mediated by a therapist who has professional boundaries (Emslie *et al.*, 2007): “they’ll be professional people so it will be fine.” (Emma). This was considered to confer positive qualities to the relationship, such as being courteous, kind and caring, as well as confidential and non-blaming. Lisa indicated that receiving professional help would be less conditional in nature: “I would want her to say, ‘that’s not the way it is’. But, in that as well, ‘I still want you to see me the next time’.” By contrast, other conversational partners may be more likely to respond from a position of subjective opinion and be influenced by their own needs within the relationship (Williams & Healy, 2001). Therapy provides the possibility of exploring issues in a context that is less tied to feelings which have its origins in transference (Philips, Werbart, Wennberg & Schubert, 2007).

Allan regarded that the bond with his therapist (Bachelor, 2013) would be significant in terms of generating mutual understanding: “it is just sometimes down to chemistry sometimes. A person either gets you or not.” Mark wanted a therapist who helped him feel at ease (Watsford *et al.*, 2013; Tambling *et al.*, 2014): “well I hope that it’s someone who I feel comfortable around”. Given the importance of a positive relationship, Adam was worried about the possibility of it being poor: “There’s a lot of that, what happens if I don’t like her”.

The therapist was expected to be responsive and accommodating, providing opportunities for collaborative decision-making and feedback (Midgley *et al.*, 2016), as explained by Simon: “if I can come up with the solution that actually works with the person and their environment, rather than forcing them to do it a different way”.

Overarching theme 3: How will I deal with my depression?

The third overarching theme, How will I deal with my depression?, brought together two themes which explain how participants see therapy helping them.

There’s always going to be a problem, um, just how do you deal with it? (John)

The theme Understanding how to get back on track captures how participants sought to deal with their depression by restoring themselves to their former, pre-depression state (Midgley *et al.*, 2016). Emma expected to track her depression back and identify its origins: “I think my next step will be letting everything out, and getting to the root cause of my depression.” Allan’s idea, that their present concerns were directly linked to their early experiences, echoed a common thread in participants’ narratives: “I would imagine a lot of stuff must go back to childhood.” This exploratory endeavour might help in finding a valid context to their depression, which could mean they are less likely to be subjected to stigmatizing views (Jones, Farina, Hastorf, Markus, Miller & Scott, 1984).

Lisa explained that understanding the origin of her experiences could be essential in preventing the recurrence of patterns of being which had contributed to her condition (Granek, 2006):

The things that happened were the things that were affecting me at the time. Now it’s different things that are affecting me but I need to take what I’ve learned from there to the new place or point in time.

Adam reported a sense of his life deviating with depression, such that he was not how he ought to be: “understand what’s gone wrong, how to try and get back on track”. Michael similarly wanted therapy to return him to a state of being how he had been previously: “returning back to how you were.” In this way, depression was understood by participants as being a loss of their “true” selves (see Midgley *et al.*, 2016), and therapy would facilitate its recovery.

Finally, the theme Whether to control or eliminate depression captures how participants sought to address their depression. Michael spoke about the importance of having conscious awareness of thoughts in order to exert mental control:

The more alert you are, the more you are able to take control of yourself basically, um sort of semi-conscious

John thought that this conscious control of their thoughts could be achieved through vigilance to his low mood and improved decision-making around his cognition: “to correct myself by my thoughts.” Emma considered it would help her to react more purposefully in managing her emotions:

You’re ignorant because you’re not consciously able take the two sides if you like, and balance them. You are just flying off the handle or making decisions just randomly

This theme also captures participants’ desire for non-talking interventions (Arch & Craske, 2008), and these were mainly expressed as non-specific expectations of adopting new practical coping strategies (Watsford *et al.*, 2013). Michael anticipated, “just putting mechanisms in place whereas you’re more able to cope with it”.

By contrast, Lisa expressed a hope that therapy would eradicate or shut down the distressing experiences associated with her depression.

Just wanting to go inside your head and mop it all out. And you just can’t do it, you can’t get in there to clean it away.

This is consistent with the expectation that therapy would ‘take away something painful’, as reported by Midgley and colleagues (p.17, 2016). This highlights the challenge for some in going for therapy, since a potential solution might lie in exposing themselves to their distressing internal experience (Abramowitz & Landy, 2013).

Like many participants, like Emma, posited an idea that they could become problem-free (Crisp, Gelder, Rix, Meltzer & Rowlands, 2000): “I’ll be able to get over it, I’ll be able to leave it, I won’t be facing those horrible things”. Lynda hoped that therapy would be a magical solution whilst finding a potential fiction in this idea: “I don’t think there is a miracle cure to be honest, I don’t think people fully recover”.

Consistent with their prior experiences, participants more often envisaged that their recovery in therapy would be ongoing and effortful. For Michael, therapy would require determination and persistence: “the hard part is to push on and keep doing it”. Allan anticipated an incremental progress towards becoming more consistent in himself, this becoming steadily more difficult: “the better you get the longer you have to practice and the more incremental it becomes, more pain equals less gain.”

Emma viewed depression as recurring and requiring continuous management: “You can fight depression all your life and be in and out of it all the time.” In addition to highlighting the antagonistic nature of participants’ relationship with depression, it is indicative of a need to transition to an idea of living with depression; in other words, adapting her self-identity (Kralik, Visentin & Van Loon, 2006).

Discussion

The findings presented describe the ways participants grapple with understanding the prospects for change in themselves and their depression through therapy, and ultimately, the question of whether they are helpable. This study confirms that having depression has an impact on expectations (Tsai, *et al.*, 2014), as feelings of hopelessness added to concerns about being trapped in a condition that were understood to reflect and amplify their own character flaws (Rhodes & Smith, 2010). Moreover, therapy was an unfamiliar concept for many needing help, making it a challenge to see therapy providing the support they seek (Codony *et al.*, 2009; Elliot *et al.*, 2015).

Participants’ accounts highlighted the impact of closed and unforgiving attitudes towards depression (Taylor and Loewenthal, 2001), which conflicted with a need to talk openly to about their problems (Watsford *et al.*, 2013; Midgley *et al.*, 2016). Through the relative safety of a good relationship (Bachelor, 2013; Tambling *et al.*, 2014) participants hoped their need for autonomy (Reynaert *et al.*, 1995) would be met through a responsive and professional therapist who furnished them with the necessary skills and knowledge (Watsford *et al.*, 2013).

Expectations for how therapy might help them deal with depression were characterised by a struggle for control over their depression, with implications for how they managed their identity. Experienced as a loss of self, for some participants, therapy would entail returning to root of their difficulties to correct the unwanted deviation in their life (Midgley *et al.*, 2016). Participants toyed with the possibility of eliminating distressing experiences (Jorm *et al.*, 1997; Midgley *et al.*, 2016), whilst better awareness and strategies (Watsford *et al.*, 2013) that promote an improved management of depression were typically seen as a challenging but necessary approach to living with it (Kralik, Visentin & Van Loon, 2006).

Overall, the findings suggest a need for mental health services to improve the provision of information in about the purpose and process of therapy (Constantino *et al.*, 2005; Watsford *et al.*, 2013), for people with depression. A poor understanding of therapy is known to negatively contribute to therapeutic expectations and engagement (Horvath, 1990; Roos & Werbart, 2013). Mind and My CAHMS choices have produced online video preparatory resources, as alternatives

to written information. Given the centrality of the relationship to these participants' conception of their recovery, pre-therapy information could address concerns about not bonding with their therapist by clarifying what they could do in these circumstances.

This study highlights the concern that people with depression continue to feel stigmatised (Barney *et al.*, 2009). Interventions aimed at changing lay attitudes towards mental health issues, such as the Royal College of Psychiatry's Changing Minds: Every Family in the Land (Crisp, 2000), have not been wholly successful, and depression remains a hidden illness to many (Elliot *et al.*, 2015). This study indicates that stigma-reduction initiatives should target attributions of blame (Barney *et al.*, 2009), and based on the concerns reported above, focus particularly on the dimensions of responsibility, repulsion, and sense of threat (Barney *et al.*, 2009). This research confirms a need to address stereotypes such as being weak or having madness, that increase social issues including marginalisation and isolation, and feelings of shame (see Clement *et al.*, 2015). Participants' reports indicate that improving people's awareness of online forums which facilitate contact with peers may improve their opportunities for normalising narratives and experiences.

Treatment expectancy has been called the "ignored common factor," (Weinberger & Eig, 1999), and it would seem prudent to view expectancy as an active ingredient to the process and outcomes of therapy (Glass *et al.*, 2001; Constantino *et al.*, 2005; Greenberg *et al.*, 2006). This study demonstrates how in practice it may be difficult to elicit specific expectations, or concrete goals, which is problematic since expectancy-response is specific to an individual's expectations (Lorber, Mazzoni, & Kirsch, 2007). For first-time clients, these findings suggest it may be helpful to ask clients whether they have any concrete experiences of help-seeking and what implications these have for their expectations. As McLeod (2012) suggests, clients are likely to know what could be helpful from existing experiences of trying different approaches. Additionally, it may be easier to discover expectancies via discrepancies that can be identified after the intervention has been explained and asking clients how this fits with their own expectations for what would happen.

Research by Devilly and Borkovec (2000) indicates therapists trying to facilitate a placebo effect should be aware that expectancy has been demonstrated to be affective in dimension. This is particularly significant in the case of people with depression, suggesting efforts need to be taken to overturn feelings of hopelessness and helplessness and generate feelings of hope (Beck *et al.*, 1993). It would seem useful to consider the discussion of expectations as an iterative process for a number of reasons: as the treatment progresses, how the client experiences both the intervention and the therapist will influence their ongoing expectations (Rutherford,

Wager & Roose, 2010); more severely depressed clients will have difficulty arousing positive expectations before therapy (Shapiro & Shapiro, 1997) but may be more receptive to attempts to modulate these once the intervention has begun. Participants' accounts highlight the importance of creating opportunities for feedback, especially in case of less-well engaged clients may reduce the risk of treatment failure (Lutz, De Jong & Rubel, 2015).

A potential limitation to this research relates to the inclusion of only non-suicidal and non-severely depressed individuals, in keeping with moral and ethical safeguards. Existing research (Tsai et al, 2014) indicates that severely depressed clients have more negative expectations, and are less amenable to pre-therapy attempts to change these. In common with other expectancy research, there is an omission around the expectations for therapy in those who could benefit from therapy to help them with depression but have not yet pursued this option. This is significant given that reluctance towards help-seeking in people with depression (Taylor and Loewenthal, 2001; Roness, Mykletun and Dahl, 2005) and because of potential implications this could have for orientating mental health services more effectively to provide earlier treatment (Montano, 1994). Future research could explore these areas further. Finally, a number of participants briefly commented on the potential importance of expectations, and since there is no known research which has explicitly set out to explore clients' beliefs about the role of expectancy, this might be a fruitful area for exploration in understanding how practitioners can work with their clients expectations.

In conclusion, this study sought to understand how people's experiences of help-seeking and depression influence their expectations of therapy, from a client perspective. It is hoped that this research further demonstrates the value in employing a phenomenological perspective to provide a richer, more detailed understanding of people's experiences of depression (Rhodes and Smith, 2010), and how they expect these experiences to change and improve through psychological therapy.

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Appendices

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Appendix 1: Recorded participant characteristics

Participant pseudonym	Age at interview	Race / ethnicity	Principle occupation	Pre-interview BDI-II score
Allan	40	White British	Musical production	18 (mild)
Lisa	43	White British	Unemployed	14 (mild)
Michael	47	White British	Production manager	21 (moderate)
Emma	28	White British	Health professional	22 (moderate)
Gareth	64	White British	Retired	20 (moderate)
Adam	45	White British	Trainer	28 (moderate)
Simon	42	White British	IT consultant	14 (mild)
James	20	Black Afro-Caribbean	Student	19 (mild)
Lynda	34	White British	Homemaker	21 (moderate)
Sarah	37	White British	Finance	20 (moderate)
John	53	White British	Self-employed	25 (moderate)
Mark	36	White British	Unemployed	16 (mild)

Participant Information Sheet

Study of expectations about counselling/therapy for depression

WE INVITE YOU TO TAKE PART IN THIS RESEARCH

Before you decide whether you want to participate or not it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear to you or if you would like more information. You are under no obligation to take part in this research. You will still be able to have counselling/therapy should you decide not to participate. **If you decide not to participate or to withdraw at any point this will not affect your future care in any way.**

WHY YOU WERE INVITED TO TAKE PART: You were contacted about the research because you have made the decision to see a counsellor or therapist about having depression, and you are between 18 and 65 years old. It is important that you haven't had counselling/therapy before, and you're not training to be a counsellor/therapy or working as one.

PURPOSE OF THE RESEARCH: This research will focus on what people understand about their experience of depression and how they think about the counselling/therapy that they are waiting for.

WHAT WE ALREADY KNOW: Research has shown that when counsellors or therapists try to understand and work with their clients' expectations that this has potential benefits.

WHY THIS RESEARCH IS TAKING PLACE: This study is being completed as part of a Professional Doctorate in Counselling Psychology, at University of the West of England.

WHAT WOULD TAKING PART INVOLVE?

Anyone taking part will be asked to complete a short assessment known as Beck's Depression Inventory – this involves rating yourself on 21 items. If the score is at the top of the scale and there are risk issues it is possible that you would be advised not to continue with the interview, for your own wellbeing. We would also like you to provide some basic information about yourself, such as your age, gender and ethnicity. If you are comfortable to continue, you will then take part in an audio-recorded interview in which you'll have an opportunity to talk about having depression and what you think about counselling/therapy. Typically, an interview might last about an hour. Afterward, the researcher will transcribe the audio-recorded interview. You will have a chance to see a copy of the transcribed interview and add any additional thoughts on the issues if you wish. This research will involve us forming an understanding about what you and other people say in your transcribed interviews.

REIMBURSEMENT: You are being asked to participate voluntarily, and as such, you would not be paid for taking part.

POSSIBLE RISKS AND BENEFITS OF TAKING PART

RISKS: We recognise that during the course of the interview, talking about your experience of depression and need for counselling/therapy might raise difficult issues and emotional discomfort. You should not take part if you think you'll find the subject matter too distressing. Similarly, you can choose not to answer any of the questions asked if you find them too difficult or upsetting, and you can stop the interview at any time for any reason whatsoever. We take our duty of care to keep you safe seriously and where participants express suicidal concerns these need to be passed on to your GP, in line with the safeguarding policy at your counselling/therapy service. It is stressed that the purpose of the interview is to carry out research and this is not in any way related to any services you may be receiving support from. We will not provide any type of counselling or therapy service to you. We would not be able to directly implement any expectation or wishes that you have about the counselling/therapy either. We will, however, try to answer any questions about the research itself.

WHO CAN I TALK TO IF I NEED HELP: If you are feeling distressed, calling the Patient Advice Liaison Service on 0117 340 6646 may help you to find the support you need. You should always contact your GP if you feel that you are in crisis. You can also get confidential support from the Samaritans (tel. 08457 909090) and Saneline (tel. 0845 767 8000).

BENEFITS: By taking part in this research you will have a chance to share your experience of seeking counselling/therapy, as an individual who has depression. It is hoped that this will help counsellors understand more about the nature and importance of their client's expectations for counselling/therapy.

OTHER INFORMATION TO TAKE INTO CONSIDERATION

HOW THE RESEARCH INFORMATION IS HANDLED: We will keep the audio-recording and the transcription of the interview securely on a computer, as required by the Data Protection Act (1998). We will remove all identifying information from the transcribed interview. Extracts will be included in the study in a way that preserves your anonymity. We will store all written materials such as the consent forms will be in a locked file. We will destroy all data and materials at the completion of the Doctoral research. It is important to let you to know that you will not be identifiable in the research report.

GETTING THE RESEARCH RESULTS: We should be able to make the results of the research available to you from the September 2016, depending on how long it takes to finish.

WHAT IS VOLUNTARY CONSENT: Giving your consent means you have read the information given about the research above, and: you understand what is being asked of you and you are happy with this; you are content with the measures taken to protect your privacy; you authorise the researcher to use your interview data. This agreement is formalised by using the Consent Form. You can keep copies of both this information sheet and your signed Consent Form. You are **free to withdraw your consent**, for any reason.

DECIDING YOU DO NOT WANT TO BE INVOLVED: You have no obligation to participate in this study and you can completely withdraw from the research at any time. This includes

withdrawing consent for your interview information to be used. The *Debrief Information* sheet explains more about your right to withdraw.

I WANT MORE INFORMATION BEFORE MAKING A DECISION: If you have any questions or concerns about to this study, please feel free to ask the researcher. If you feel that the researcher cannot give you the information you want, please feel free to contact Dr. Toni Dicaccavo, Director of Studies. Our contact details are provided below.

WHAT IF YOU HAVE A COMPLAINT: If for any reason you become dissatisfied with your involvement you can direct any issues toward the Director of Studies, Dr Toni Dicaccavo (contact details are provided below). Alternatively you might want to ask for the Patient Advice Liaison Service on 0117 340 6646.

HOW TO CONTACT THE RESEARCHERS:

Dan Lewis – Daniel7.Lewis@live.uwe.ac.uk (tel. 07789873985)

Dr. Toni Dicaccavo – Toni.Dicaccavo@uwe.ac.uk (tel. 0117 32 82181)

Dan Lewis,

A handwritten signature in black ink, appearing to read 'Dan', followed by a long horizontal flourish.

Trainee Counselling Psychologist,
University of the West of England.

Appendix 3: Consent Form



University of the
West of England

CONSENT FORM

Research study: Expectations about counselling for your depression

Dan Lewis (Daniel7.Lewis@live.uwe.ac.uk)
Trainee in Counselling Psychology
University of West of England

Please initial box

- | | | |
|----|--|--------------------------|
| 1. | I confirm that I have read and understand the <i>participant information sheet*</i> for the above study and have had the opportunity to ask questions. | <input type="checkbox"/> |
| 2. | I understand that my participation is voluntary and that I am free to withdraw, without giving a reason. | <input type="checkbox"/> |
| 3. | I agree to the interview being audio recorded | <input type="checkbox"/> |
| 4. | I agree to the use of anonymised quotes in publications | <input type="checkbox"/> |
| 5. | I understand that the NHS Trust and the University of the West of England may wish to examine the information you provide for this research. | <input type="checkbox"/> |
| 6. | I agree to take part in the above study. | <input type="checkbox"/> |

Name of Participant

Date

Signature

Name of Researcher

Date

Signature

Appendix 4: Interview schedule

CHANGE WITH DEPRESSION

- How, if at all, has depression affected how you are in yourself? What do you do differently? What is the worst thing about depression?

HELPSEEKING

- When the depression began how did you cope? Have you tried to do anything specific to manage it? What were you trying to achieve?
- Did you ask for any kind of help from others? How did others support you? How did others fail to support you?
- What brought you to therapy / counselling? How easy was it to decide to come for therapy?

EXPECTATIONS

- What will it feel like going to talk to another person about your depression? How will you feel toward the therapist? What does needing therapy say about you?
- What do you think therapy is about? What might happen during the course of therapy? What will the therapist expect of you in therapy? What will the therapist be trying to do and how will they do this?
- What are the good and bad things about coming for therapy? What would be the best outcome of therapy and how close to achieving that will you get? How will you know if therapy is working? How would you deal with a situation where the therapy is not how you wanted it to be?

ADDITIONAL ENDING QUESTIONS

- Is there anything that you would like to add on the subject of having depression and your expectations for therapy?
- Some of the questions asked will have meant that you have talked about challenging aspects of your personal life. Having spoken about these, I wonder if I could ask you how you feel in yourself?

Appendix 5: Debrief Information



DEBRIEF INFORMATION

Research study: Expectations about counselling/therapy for your depression

Thank you for taking part in this study. If you have any questions about the study or would like to say anything about your experience of participating then please feel free to talk to me about this.

Background Information about the study

This research intends to investigate what people expect when they see a counsellor or therapist about depression. As part of this we wanted to understand more about your story, including what has changed about you as a person with depression, how you tried to resolve any difficulties associated with the depression, what prompted you to see a counsellor/therapist, and how these things have affected your expectations about the counselling/therapy you are waiting to receive.

The government's NICE guidelines provide information about the types of intervention that are most effective for different conditions. For depression and other mental health conditions the guidelines focus on the most effective type of counselling/therapy (such as cognitive-behavioural therapy, cognitive analytic therapy, mindfulness etc). In the "common factors" approach, the evidence for what is most effective in therapy was examined (Lambert, 1992). They found that the technicalities associated with any particular model of therapy were less important to the effectiveness of the counselling/therapy than other factors. These factors included the relationship between the counsellor/therapist and the client, and the clients' expectations about the therapy.

Studies trying to understand the effects of people's expectations on counselling/therapy have tended to be large scale studies using questionnaires, and they typically categorised expectations into one of two types: expectations about what will happen during the counselling/therapy, such as what roles the client and counsellor/therapist might adopt; expectations about what the result of going for counselling/therapy might be. These studies have not led to a consistent set of findings and it may be because they have not examined the issue in enough depth. We took the decision to interview people waiting for counselling/therapy about their particular journey, and their expectations for that counselling/therapy. This study hopes to understand people's expectations for counselling/therapy better, specifically in the context of having depression.

Please remember that you have **the right to withdraw the information** that you gave. All you have to do is to send an email to Daniel7.Lewis@live.uwe.ac.uk with your ID number,

clearly stating that you wish to withdraw your information from the study. Alternatively you can ask the therapy/counselling service to pass on your decision to withdraw from the study, again citing your ID number. Your ID number can be found at the top of your Participant Information Sheet.

Sometime after the interview has taken place a typed transcript of the audio-recorded interview will be produced and sent to you. You can, if you wish, send additional information if you think this will help to explain further some of your thoughts about the issues we talked through. Remember that even after you have received the transcript **you can still withdraw your information.**

This research will involve an analysis of your information in combination with other participants' information. After a certain point in the analysis it would be a challenging process to try to untangle and eliminate any individual's information. It therefore makes sense to give participants a reasonable amount of time to consider the information you have given and also to **have the opportunity to withdraw it**, if this is what you wish. A period of **28 days** after you have received a copy of the transcript is given for this purpose.

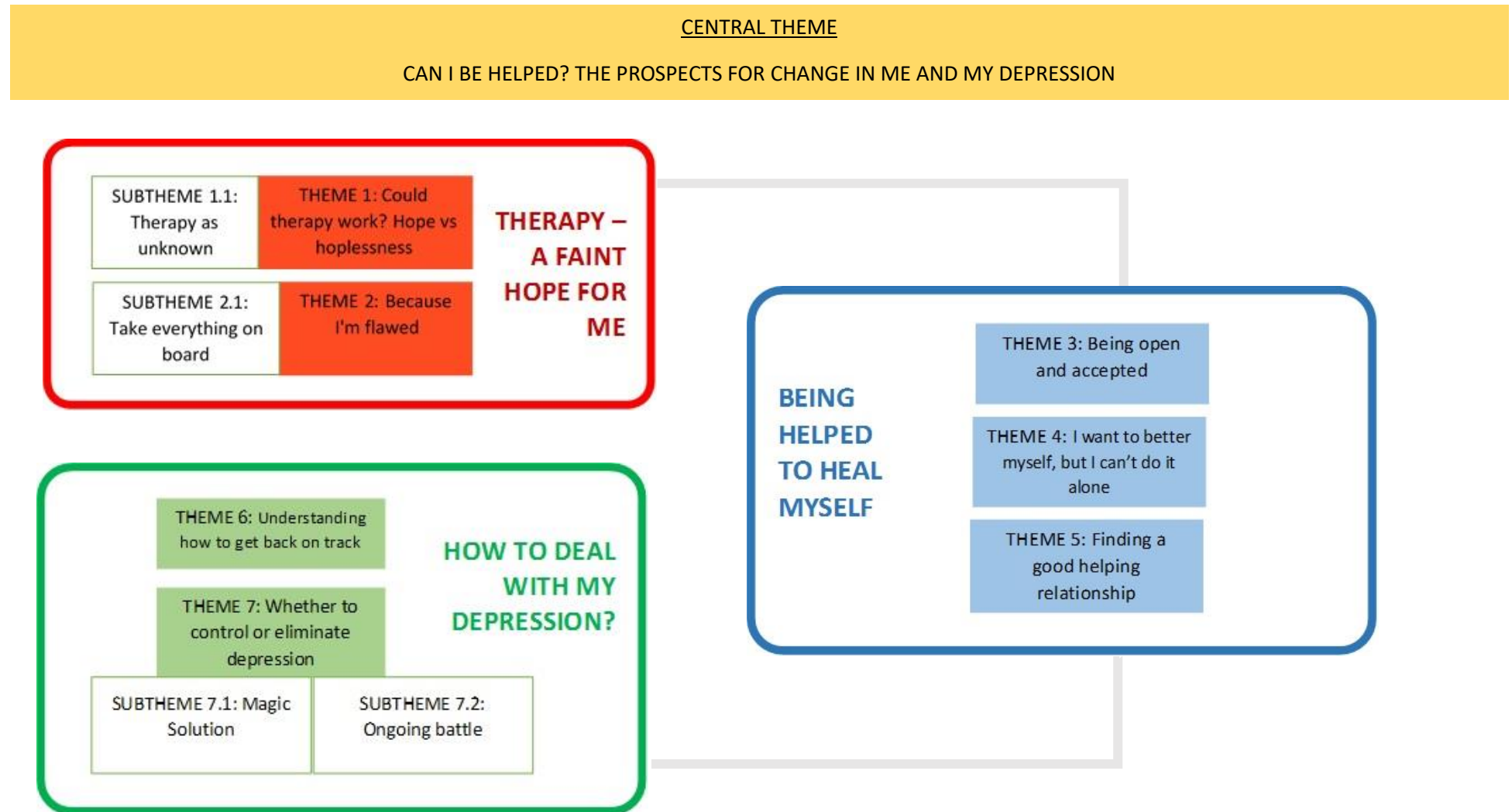
It is possible that you may have experienced some distress as a result of talking about your depression/anxiety. If this is the case, then you may wish to contact the following support services:

- Depression Alliance (www.depressionalliance.org): self-help for people with depression
- Journeys (tel. 02920692891): support for people with depression
- Supportline (tel. 01708 765200): helpline for individuals with emotional distress
- Rethink (tel. 0300 5000 927): support and advice about mental health issues
- Mind (tel. 0300 123 3393): support and advice about mental health issues
- Saneline (tel. 0845 767 8000): information and crisis support
- Samaritans (tel. 08457 909090): 24hr confidential, emotional support
- Papyrus (tel. 0800 068 41 41): for young people thinking about suicide
- Calm (tel. 0800 585858): support for men between 15-35
- First Steps to Freedom (tel. 0845 120 2916): advice and support for people with anxiety
- Anxiety UK (tel. 08444 775 774): helpline for information on counselling
- NHS (tel. 111): helpline for any health issues

If you have any comments or concerns about the study, please email me Daniel7Lewis@live.uwe.ac.uk or Dr. Toni Dicaccavo, Director of Studies Toni.Dicaccavo@uwe.ac.uk

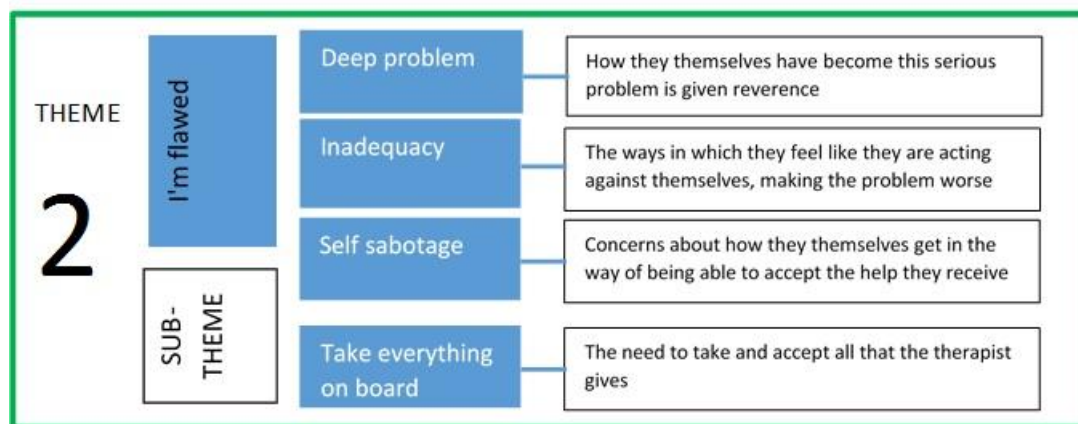
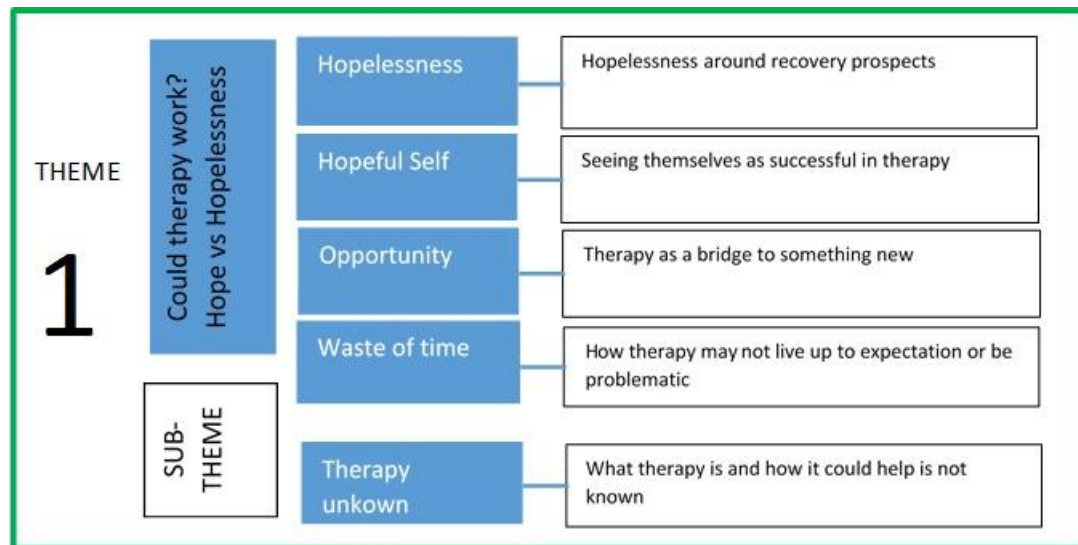
Thank-you once again for participating in this study.

Appendix 6: Thematic Map

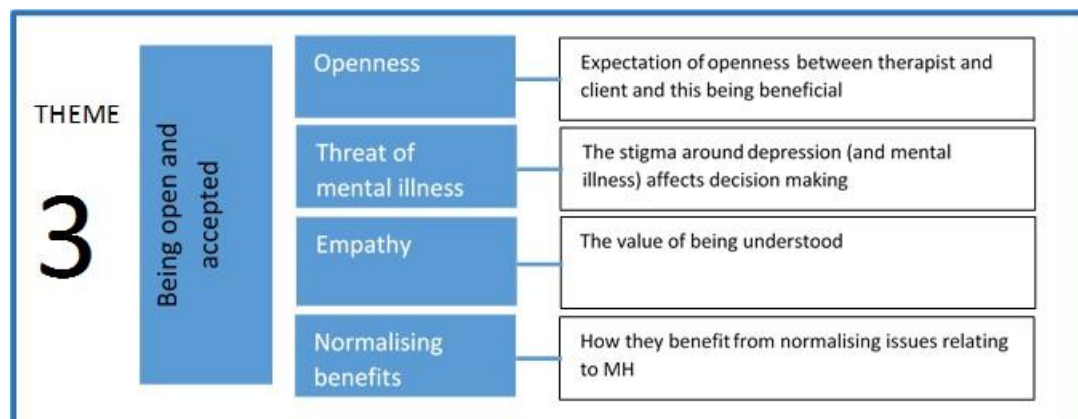


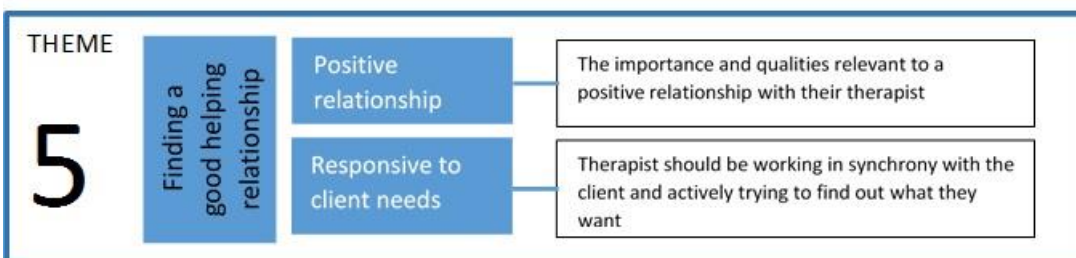
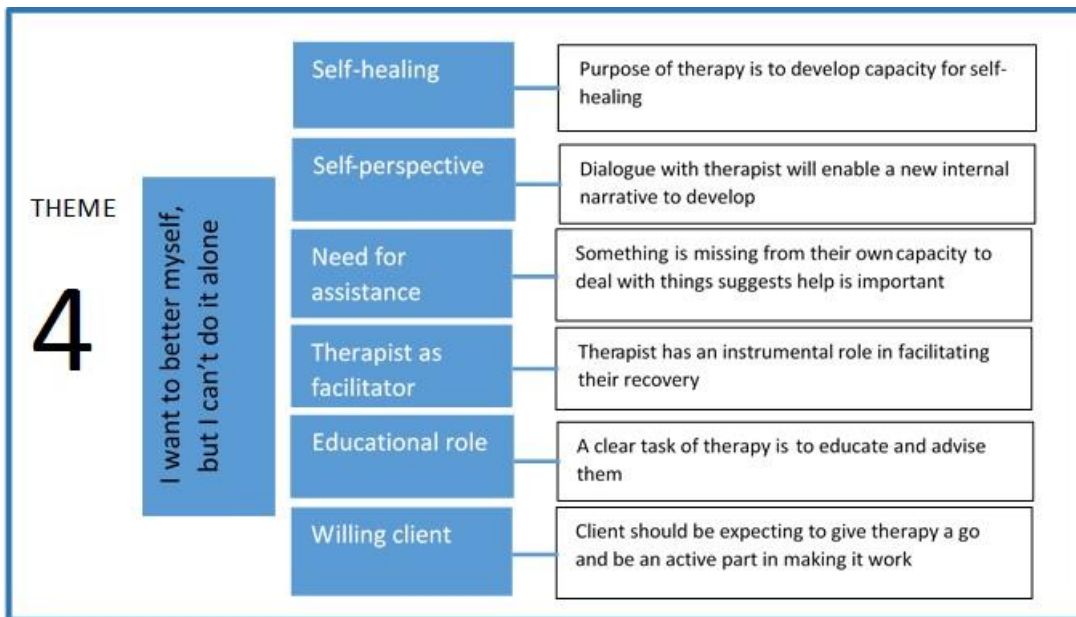
Appendix 7: Code definitions

OVERARCHING THEME 1: Therapy – a faint hope for me

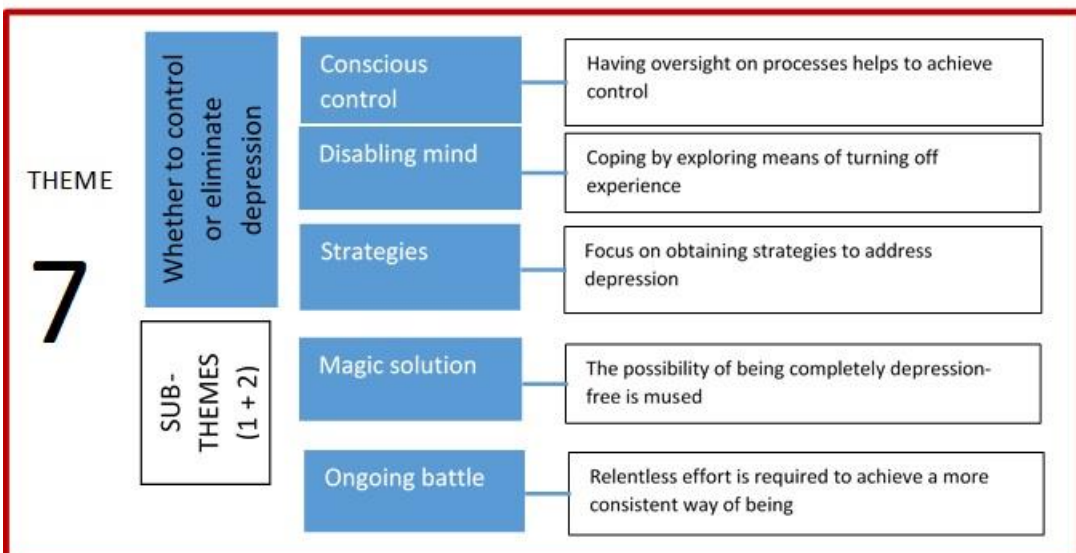
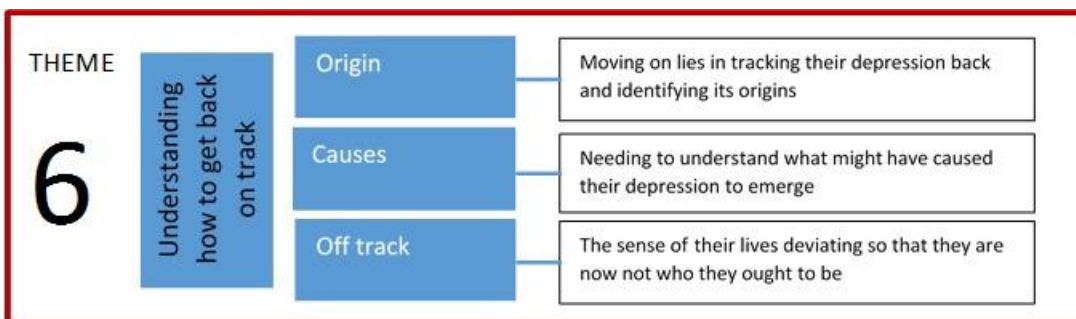


OVERARCHING THEME 2: Being helped to heal myself





OVERARCHING THEME 3: How will I deal with my depression?



Appendix 8: Examples of data extracts

Theme	Therapy could help but why would it	I'm flawed	Being open and accepted	I want to better myself, but I can't do it alone	Good helping relationship	Understanding how to get back on track	Whether to control or eliminate depression
Selected Code	Hopelessness	Inadequacy	Openness	Self-healing	Helping relationship	Origin	Conscious control
Code description	Expressions of hopelessness around recovery prospects	The ways in which they feel like they are acting against themselves, making the problem worse	Expectation of openness between therapist and client and this being beneficial	Purpose of therapy is to develop capacity for self-healing	The importance and qualities relevant to a good relationship	Moving on lies in tracking their depression back and identifying its origins	Having oversight on processes helps to achieve control
Sample extracts	<p>I'm thinking how will i control it when I'm feeling down. Because i can't (Emma)</p> <p>when I'm really down and everything goes tits up, and then its really hard to get out of once you're in like the circle of things, which is....annoying, its just trying to get</p>	<p>Disappointment for me is worse than feeling sad. It's [laughs] really bad, so I tend not to accept my expectations too high, but I have to be careful, if I set my expectations too low that can affect the outcome or itself, cos it can affect how much effort you put into it, so I'd try and put it in the middle words</p>	<p>I imagine that y'know you have to um like you have to be honest about things if you want the best help from the therapist y'know. (John)</p> <p>I'm just trying to work out how to answer that, um, first of all you've just got to be able to confide in the person. If you</p>	<p>That's my first guess, um, from what I've heard as well it's to do with helping you understand what you're going through so that you can deal with it yourself. (Michael)</p> <p>that's not to say we shouldn't try to fix those problems y'know we should hopefully keep on</p>	<p>Well I hope that y'know that someone who I feel comfortable around them like someone I can trust. (Mark)</p> <p>If I didn't feel comfortable around them for some reason then I think that would make it hard and like maybe I'd want to hold back,</p>	<p>I think my next step will be letting everything out, and getting to the root cause maybe of my depression (Emma)</p> <p>I mean I would imagine given that um a lot of stuff I mean y'know must go back to childhood and all that stuff. So I would imagine....hopefully I will be exploring</p>	<p>It's just something I've always been aware of, like the power of the mind, I've always been aware of that, you could say, but my identification of what is happening to you is like the first step. (James)</p> <p>Well I'm reasonably</p>

	<p>back to that good, I really struggle on when i get caught up in the cycle, and it doesn't take a lot to tip me. (Emma)</p> <p>Y'know, suddenly nothing is really going to work [raised voice]. Y'know, your relationship isn't going to work, you won't be able to work. (Allan)</p> <p>It just feels like you're being drawn down, y'know, you had all this confidence and suddenly you're just going down this funnel. Your confidence is going more and more and more. (Allan)</p>	<p>can go either way. (James)</p> <p>I feel safe in there. I just don't like going out, y'know, I've just completely gone off it, I feel.it's trying to describe it...[exhales] I'm probably not making sense [laughs], um but I feel safe, in my own little world if that makes sense (Emma)</p> <p>I think, because i can't manage myself i think i can't manage my children, i think i can't manage my marriage, i think i can't manage everything. (Emma)</p>	<p>can't confide with a person, or talk openly with them, then It's not going to work is it. (Gareth)</p> <p>Erm, yeah I think honesty, I think they will expect me to say it all, warts and all (Lisa)</p> <p>I'm quite open to talk about myself, um. So that might be quite difficult for someone, I don't know because.... But uh, I'm looking for someone to be honest with me really (Allan)</p>	<p>making improvements to make our life constantly better (Simon)</p> <p>How will i know whether it is working? Knowing whether the empowerment's there when I'm feeling down I guess. (Sarah)</p> <p>Um, I think in myself I will feel stronger. I'll feel like I'm managing [spoken slowly] things better. I feel like it will give more opportunity it will strengthen my confidence and things like that (Emma)</p>	<p>basically resist it a little bit, if you get what I mean. (Lynda)</p> <p>She wouldn't be doing her job if she wasn't an approachable person, on the other hand. (Adam)</p> <p>It's needs to be somebody you're gonna be able to open up, somebody you're gonna be able to like. (Adam)</p> <p>I'll be very nervous at first I think but the more I talk, the more I let out, the more I'll feel ok about it, you just get a connection and then just go with it. (Emma)</p>	<p>some areas that [inhales]....don't come out too often really. (Allan)</p> <p>Just thinking about when I was living with my granny and my granddad and things, the things that happened then happened for a reason, erm, good or bad, and if I can learn anything from then. (Lisa)</p> <p>Because I think, er, maybe the things that happened were at that sort of point in time and those for the things that were affecting me at the time. Now it's different things that are affecting me but I need to take what I've learned from there to the new place or point in time. (Lisa)</p>	<p>convinced that if I can get over the psychological barrier of what I feel is a seasonal depression then the only way I am really going to do that is by some sort of mind discipline. (Gareth)</p> <p>Or when my thoughts in my mind are no longer taking over. Once I'm able to totally...and here with you I'd been able to pull things apart and...but when you're at work and whatever things build up you just do things randomly. Want to stop doing the random things and I feel comfortable with myself I think I'll stop looking. (Mark)</p>
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Appendix 9: Journal article

The research article presented before these appendices has been prepared for submission to the Journal of Psychotherapy & Counselling Psychology Reflections (JPCPR). This is an international peer-reviewed journal from Regent's University London whose particular intention is to bridge academic and applied paradigms of psychology, and espouses the scientist-practitioner model. The journal was specifically chosen because its intention is to represent research from the field of counselling psychology, and it would seem important for this research to be communicated to a community whose values are consistent with the background, philosophy and epistemology of this study. The journal supports a pluralistic position which is well aligned to the heart of my research. Additionally, it encourages submissions that are of a reflective nature, which is congruent with the kernel of my training, and counselling psychology in general.

Guidelines for submission

The research article will be written and presented according to the following guidelines for the submission of articles to JPCPR. The guidelines were obtained from: <http://www.regents.ac.uk/media/2158312/guidelines-for-submissions-jpcprv2.pdf>.

Language

Papers are accepted only in English. British English spelling and punctuation is preferred. Non-discriminatory language is mandatory. Sexist or racist terms must not be used.

Referencing

All manuscripts should follow the referencing guidelines in the 6th edition referencing system of the Publication Manual of the American Psychological Association at: www.apastyle.org/manual/

Abstracts

Structured Abstracts of no more than 250 words are required for all papers submitted. Authors should supply three to six keywords.

Headings

Section headings should be concise.

Word count

A typical manuscript will be 1,500-2,500 words, including references. Longer contributions of 3,500-6,000 words, (27-30 double spaced pages including references) may be published where inclusion of data (e.g., excerpts from interviews) warrant it. Papers that

greatly exceed this will be critically reviewed with respect to length. Authors should include a word count with their manuscript. The word count (which includes all text including the abstract, manuscript, notes, tables, figures, etc.) should appear at the end of the manuscript.

Font

All manuscripts must be typed in 12-point font in Arial and double-spaced throughout including the reference section, with wide (3 cm) margins. All pages must be numbered.

Manuscripts

Manuscripts should be compiled in the following order:

(1) Title of manuscript, (2) Author(s) name(s) and title(s), (3) Abstract (4) Keywords (no more than six), (5) Correspondence/contact details including author(s) affiliation(s), (6) Main text, (7) References, (8) Acknowledgements, (9) Appendixes (as appropriate), (10) Table(s) with caption(s) (on individual pages), (11) Author(s) biographical outline (50 to 100 words).

Additional guidelines

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